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AUTHOR Northup, Lindell C.
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ABSTRACT

This leader training kit is designed to help leaders teach their audience about a major consumer purchase--health care coverage. It is organized so that the participants should be better able to (1) assess their individual/family health care needs; (2) use appropriate guidelines to select and purchase health care coverage in order to get the most protection for dollars spent; and (3) use their plan in order to maximize benefits. Each of the five unit guides contains an overview, consumer objectives, lesson outlines and suggested learning activities, fact sheets, and supplementary materials. Each guide is designed to be used independently of the others, depending on the audience and their needs. The guides cover the following topics: health care costs and major trends; matching health care needs with options for coverage; evaluating and selecting health care plans and policies; using health care plans to maximize benefits (filing health insurance claims, filing an insurance complaint in Ohio, and the new rules for health care coverage); and senior citizens and health care coverage (Medicare and supplemental policies). A glossary, crossword puzzle, and seven brief circulars containing practical advice for consumers complete the kit. (KC)

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Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE

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"ACTUALLY, DR., OUR TERRIBLE HEADACHES
STARTED WHILE WE WERE DECIDING BETWEEN
FIFTEEN DIFFERENT HEALTH CARE PLANS..."

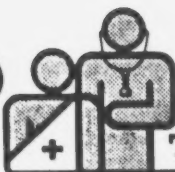


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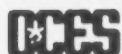
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Making Sen\$e of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



A LEADER TRAINING RESOURCE KIT

This kit has been developed as part of a special research and training project of the Cuyahoga County Cooperative Extension Service, The Ohio State University and supported by The Cleveland Foundation.

LINDELL C. NORTHUP
Project Director

SALLY K. EBLING
County Extension Chairman

"Making Sen\$e of Health Care Plans: The Consumer's Guide To Health Care Coverage" is a set of materials designed to help leaders organize and conduct training for their own audiences. The kit is organized in such a way so as to provide necessary lesson plans, fact sheets, and support materials.

The overall goals of this educational tool include helping consumers to assess their health care needs; to use appropriate guidelines to purchase coverage which will provide adequate protection for dollars spent; and to utilize the plan they select in such a way as to receive maximum benefits.

Prepared by Lindell C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service, The Ohio State University, 6/86.

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Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture, J. Michael Sprott, Director of Ohio Cooperative Extension Service, The Ohio State University.

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ALBERTA JOHNSON
Greater Cleveland Coalition on
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CAROLYN CALDWELL
Golden Age Centers of
Greater Cleveland

CYNTHIA WEIR
Cuyahoga County League of
Women Voters

MARK WITT
Cleveland Office of Consumer
Affairs

JOYCE E. DAVIS
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NANCY ROTH
Health Systems Agency of
North Central Ohio

SYLVIA RODRIGUEZ
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GLOSSARY AND CROSSWORD PUZZLE

HOW TO USE THE LEADER TRAINING KIT

This leader training kit is designed to help you, the leader, teach your audience about a major consumer purchase - health care coverage. It is organized in such a way that after participating in all the lessons, the participants should be better able to:

1. Assess their individual/family health care needs.
2. Use appropriate guidelines to select and purchase health care coverage in order to get the most protection for dollars spent.
3. Utilize their plan in order to maximize benefits.

Each of five leader teaching guides contain:

Consumer objectives

Lesson Outlines and Suggested Learning Activities

Fact sheets

Supplementary materials

However, each guide is designed to be used independently of the others, depending on your audience and their needs, the amount of time available, or the number of sessions to be conducted. Target audiences who would benefit from the materials in this kit include:

Young adults (the group most likely to be without health care coverage)

Employees who must select from a number of group health care plans

Individuals who must purchase individual (non-group) health care coverage

Pre-retirement persons who need to begin planning for protection after age 65

Senior citizens who must purchase coverage to supplement Medicare.

In addition, lesson outlines within the teaching guides may be used independently to better meet the needs of the particular audience or if a series of sessions is planned. Try to determine your audience's needs or interests in advance. To do this, you could speak with the staff or officers of the group and ask them what they think the needs are. If possible, you could develop a brief questionnaire and ask that it be completed in advance of your training by the proposed participants. If more than one session is planned, you could use a questionnaire prior to the next meeting or take a simple poll of those present. The number of suggested learning activities you choose will also depend on the length of time available. Before you select the activities, be sure you read through all the materials.

BEFORE THE TRAINING

1. Review the "Leader Teaching Guides" containing lesson outlines and activities for the section(s) you will be using.
2. Study the lesson outline, review background information, select learning activities and make changes as needed.
3. Duplicate any handouts selected.
4. Assemble needed materials and equipment.
5. Obtain a room with enough tables so that participants will have adequate table top space to spread out their packet of materials as well as allow them to participate in group or individual written activities.

PRESENTING THE LESSON

1. Make sure that the meeting room is ready, such as the placement of chairs for best viewing, adequate room lighting, and proper room temperature.
2. Assemble needed materials and equipment, if any, and arrange for easy use. Be sure equipment is working properly.
3. Give objectives of the lesson and a brief overview of what is to be covered.
4. Proceed with the lesson, using selected learning activities.
5. Conduct question and answer or comment period. Allow participants to share experiences.
6. Administer training effectiveness questionnaires.

NOTE: The information in these materials was current as of the writing of this kit (January 1986). Statistics and other figures (on costs, for example) change frequently. The leader should update prior to a presentation, whenever possible.

To simplify information in this publication, trade names of some products and/or services are used. No endorsement is intended, nor is criticism implied of similar products not named.



**MAKING SENSE OF HEALTH CARE PLANS:
THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE**

CUYAHOGA COUNTY
COOPERATIVE EXTENSION SERVICE
3200 West 85 Street
Cleveland, Ohio 44102
(216) 831-1890
(216) 831-3450

TRAINING EFFECTIVENESS QUESTIONNAIRE

Your feedback on the training in which you have just participated is very important. Thank you for taking the time to fill out this questionnaire.

YOUR NAME (OPTIONAL): _____

ORGANIZATION: _____

Please check the lessons in which you participated:

- I. Overview _____
- II. Matching Health Care Needs with Options for Coverage _____
- III. Evaluating and Selecting Health Care Plans and Policies _____
- IV. Using Your Plan to Maximize Benefits _____
- V. Senior Citizens and Health Care Coverage _____

Please rate the following on the scale below by checking (✓) the appropriate box:

	Excellent 5	4	3	2	Poor 1
<u>TRAINING EFFECTIVENESS:</u>					
1. Clarity of goals/ objectives of training					
2. Overall organization and presentation of the training					
3. Degree to which you feel objectives were achieved					
<u>CONTENT:</u>					
4. Degree to which you gained new knowledge					
5. Helpfulness of informa- tion received					
6. Value of information received					
7. Degree to which you learned a new skill(s)					
8. Degree to which you feel you will be able to apply the information					
9. Degree to which you feel you will be able to convey the information to others					

We appreciate any additional comments you might have to make. Please do so on the back of this form.



Making Sen\$e of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE

OCCES OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



I. OVERVIEW

This section provides an overview of the problem of rising health care costs and how high costs have impacted on the health care system. Major trends caused by rising costs are also described.

CONSUMER OBJECTIVES:

After completion of this section of the leader training, participants should be able to:

1. List three reasons for rising health costs.
2. List three recent changes in the health care system relating to coverage brought about by rising health care costs.
3. Describe one major trend in health care coverage which will impact on consumers in the next decade.

Prepared by Lindell C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service, The Ohio State University, 6/86.

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LEADER TEACHING GUIDE

I. OVERVIEW

A. RISING HEALTH CARE COSTS AND HOW THEY IMPACT ON THE HEALTH CARE DELIVERY SYSTEM

Lesson Outline

Suggested Learning Activities

- I. Since 1975 the amount of money Americans spend on health care has nearly tripled from \$133 billion to approximately \$391 billion in 1984. Health care makes up nearly 11 percent of the Gross National Product (GNP).¹

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

- A. In 1984 Ohioans spent \$14.7 billion - up from \$3.8 billion in 1970 - for health services. This represents 10.5% of Ohio's Gross State Product (GSP).²

Review "An Answer To the Rising Cost of Health Care," Health Insurance Association of America.

- B. Between 1978 and 1985 the average cost per day for a semi-private hospital room rose from \$110 to \$212. The average rate in Ohio by 1985 was \$229.³

On board or flip chart, highlight underscored statistics.

- C. In 1983, Cleveland had the highest cost per hospital case of any other Ohio city, \$4,345 as compared to a national average of \$2,789 and \$2,917 for Ohio as a whole.⁴

¹ Source Book of Health Insurance Data, 1984-1985, Health Insurance Association of America, 1850 K Street, N.W., Washington, D. C. 20006, p. 40.

² 1984 Governors Commission on Ohio Health Care Costs, Final Report.

³ Source Book of Health Insurance Data, 1984-85, p. 59.

⁴ Plain Dealer, July 9, 1985, p. 2-E.

NOTE: The information in these materials was current as of the writing of this kit (January 1986). Statistics and other figures (on costs, for example) change frequently. The leader should update prior to a presentation, whenever possible.

II. Reasons behind skyrocketing costs include:

- A. Inflation
- B. Kind and amounts of services
 - 1. Expensive Technology
 - 2. Defensive Medicine
 - 3. Lack of Incentives To Reduce Costs
- C. Aging Population

Display and discuss Exhibit I-A, "Reasons for Rising Health Care Costs." (May be made into a transparency for overhead projector.)

III. In 1982, the nation's health care dollar came from:

- A. Private health insurance and other third party payors - 29.5%
- B. Direct patient payments - 28%
- C. Medicare - 16.18%
- D. Medicaid - 10.54%
- E. All other federal programs - 7.14%
- F. Other State/local government programs - 8.58%

Display and discuss Exhibit I-B, "Nation's Health Dollar in 1982 - Where It Came From."

IV. In 1982, the nation's health care dollar went to:

- A. Hospital Care - 42.04%
- B. Physician Services - 19.17%
- C. Nursing Home Care - 8.48%
- D. Other Health Spending - 11.01%
- E. Other Personal Health Care - 19.31%

Display and discuss Exhibit I-C, "Nation's Health Care Dollar in 1982 - Where It Went."

V. American business pays the greatest portion of private and public health insurance, over \$100 billion in 1983.

In 1950, health insurance costs were less than 1% of payroll. By 1981, they were over 5% of payroll.

Display Exhibit I-D, "Health Insurance Costs As Percent of Payroll."

OUTLOOK

A newsletter for community and consumer organizations reporting on issues affecting the life and health insurance business and the general public.

Community and Consumer Relations • American Council of Life Insurance
Health Insurance Association of America

An Answer to the Rising Cost of Health Care: An Industry Perspective

It is impossible to put a price tag on human life. Because our health is such an important asset, Americans are willing to spend great amounts to stay well. Since 1975, the amount of money Americans spend on health care has nearly tripled, from \$133 billion to an estimated \$391 billion in 1984. Health care now makes up nearly 11 percent of the Gross National Product. Consumers spend more on their health care than they do on tobacco, private education, recreation and leisure activities combined. According to a 1984 Health Insurance Association of America survey, "Health and Health Insurance: The Public's View," health care costs are identified by the public as the primary health care issue facing the nation. (Approximately 3 in 4 Americans correctly believe health care costs are going up at a faster rate than other costs.)

What has contributed to this disturbing problem? Fingers can be pointed in many directions. One obvious reason for the escalating cost of health care has been overall inflation. However, even though inflation has receded, health care costs continue to outpace the general rate of inflation. Currently they are rising about twice as fast as all other items in the Consumer Price Index. To put it in more personal terms, the average cost of a day in a semiprivate hospital room nearly doubled in the years from 1978 to 1984—from \$110 to \$209.

The major pressures today for continued health cost inflation include the expenses associated with advances in medical technology coupled with staffing large numbers of highly skilled professionals, the insulation against these costs

through the growth of private health insurance, the growing elderly population who incur a disproportionate share of health care expenditures, and the lack of cost saving incentives and normal marketplace forces to spur competition and hold prices down for health care consumers.

Cost Containment Efforts

Many public and private sector efforts, however, are being made to contain health care costs.

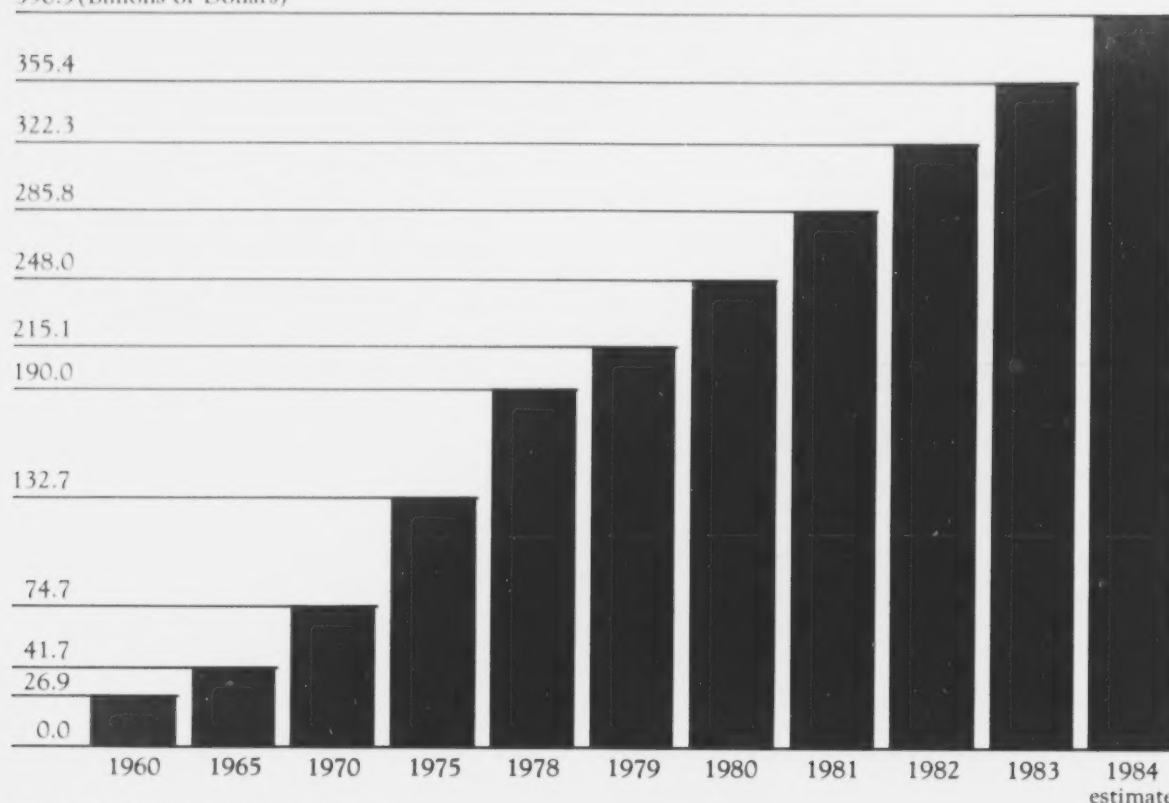
Increasing emphasis is being placed on alternatives to the most expensive form of care—inpatient hospitalization. Many private health insurance plans today cover surgery performed in ambulatory surgery centers, hospital pre-admission testing and home care. Interest also is rising in hospice care for the terminally ill.

In addition, growing numbers of people are enrolling in health maintenance organizations (HMOs) which provide a wide range of services, including preventive care, to patients for fixed fees paid in advance.

Another potential restraint on the cost of health care over the longer term is the rising public interest in health-related activities, such as diet, nutrition and exercise programs. Many of these programs are offered in community settings. In addition, growing numbers of employers, encouraged by the Health Insurance Association of America and health insurance companies, are offering programs at the worksite to help employees—and often their families—stop smoking, improve their diet, manage stress and overcome alcohol and drug abuse.

National Health Expenditures and Percent of Gross National Product

390.9 (Billions of Dollars)



Source: Health Insurance Association of America

Federal Government Initiatives

The Federal government, alarmed by rising Medicare expenditures and dwindling reserves, is also seeking ways to reduce health care costs.

In tandem with budget-cutting legislation passed in 1982, Congress passed additional legislation in October 1983 that changes the way hospitals are reimbursed for Medicare patients.

As part of the Social Security Amendments of 1983, this legislation replaces the current system of Medicare reimbursement to hospitals with a new *prospective payment plan* which essentially determines in advance what hospitals will be paid for services provided to Medicare patients. Previously, the Federal government had allowed hospitals to determine charges *after* service had been performed. This method offered no incentives for efficiency and economy.

The new "prospective" system, however, uses a complex formula, based primarily on a patient's diagnosis, to determine just how much a hospital will be paid for its services. Some 470 "diagnosis-related groups" (DRGs) are used as part of the reimbursement formula. Under this system, a

preset payment is made to the hospital, regardless of the length of the patient's stay or the extent of services (tests, medication) provided. Notably, the new system applies only to hospital services—such as room, board and laboratory tests—and not physicians' fees. Adjustments in DRG rates can be made in exceptional cases.

If the hospital can treat the patient for less than the "pre-set" rate, it can keep the savings. If treatment costs more, the hospital cannot bill the government or increase charges to Medicare beneficiaries above current levels. It is hoped the system will encourage hospitals to curtail unnecessary tests, reduce lengths of stay, and/or prescribe less costly medication.

There are presently 467 DRG categories and three special categories. Several types of health care providers, including psychiatric, rehabilitation, long-term and children's hospitals, are exempt from the system. They will continue to be reimbursed as they always have been.

To account for regional price differences, not every hospital will receive the same payment for each DRG category. For reimbursement purposes,

the country has been divided into nine regions, each with an urban and a rural rate. Over the next few years, the Department of Health and Human Services plans to move toward uniform, national urban and rural rates, phasing out the original differences.

Cost Shifting

While the DRG legislation marks a dramatic change in the way hospitals are paid, a prospective payment system that only focuses on Medicare reimbursement will result neither in lower hospital costs nor in lower overall health care costs. If the payment received under Medicare DRG regulations is not sufficient to cover the patient's costs, a hospital has two choices: it can draw upon hospital reserves, if any, or it can charge other patients more to compensate for the reduced government reimbursement. The latter practice is called cost-shifting and most hospitals practice it to preserve their fiscal integrity.

Since 1965, Medicare expenditures have been escalating. During this time, government reimbursement rules have changed in order to reduce government payments. However, reductions have not lowered spending, they have simply shifted more and more hospital costs to private patients, including those covered by Blue Cross/Blue Shield, commercial insurers and those who are uninsured.

In 1981, \$5.0 billion was shifted to private sector payers; in 1982, it rose to an estimated \$5.8 billion. Current estimates put the cost shift for 1984 at \$8.8 billion.

Cost shifting is unfair for several reasons. One, it is unfair that a large portion of the hospital bills of private patients is not for their own care—over which they may be able to exert some control—but for care given to other patients. In fact, a typical private sector hospital bill would be almost 13 percent lower in the absence of the government cost shift. Two, the cost of providing some hospital services, such as charity care and some educational research, are paid for only by private patients. And, three, the financial stability of inner-city and teaching hospitals is threatened because of their high numbers of Medicare/Medicaid patients and low numbers of private patients onto whom costs can be shifted.

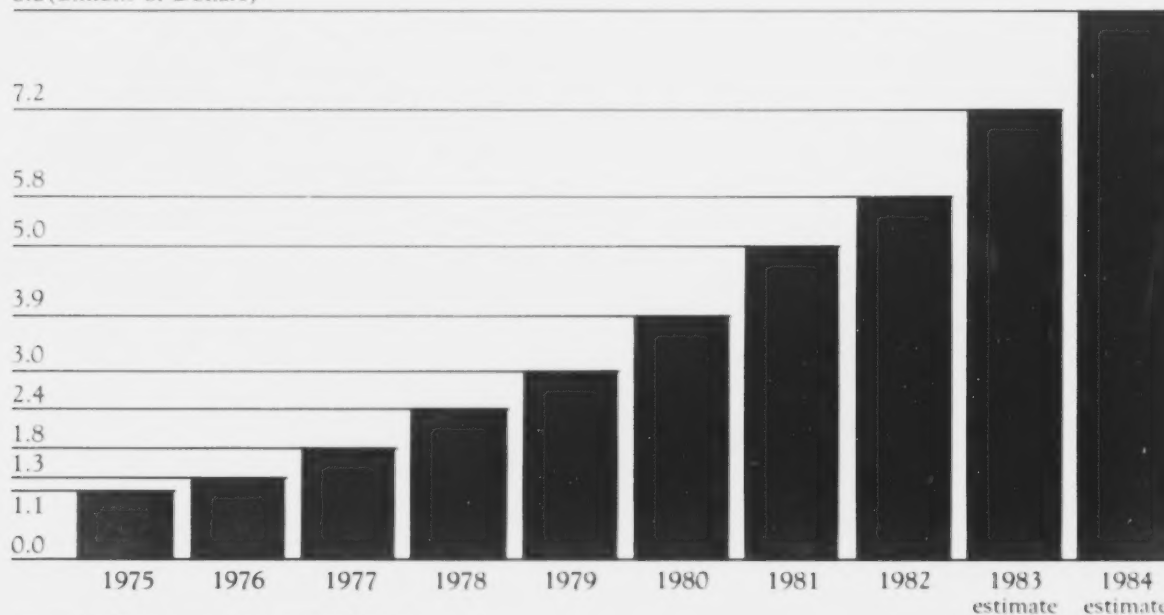
A Fair Payment System

There is a solution. The 1983 Social Security Amendments recognize the rights of states to adopt a system that requires all payers to pay hospitals on the same basis for the same treatment. The Health Insurance Association of America calls such a prospective payment arrangement a "Fair Payment System."

In specific terms, this means that the Federal government must permit states—if they meet

1975-1984 U.S. Short Term Hospital Total Government Payment Shortfall

8.8 (Billions of Dollars)



Source: Health Insurance Association of America

certain criteria—to put a system in place that enables hospitals to charge Medicare/Medicaid patients on the same basis as all other patients and to withdraw from the national DRG system. This practice is allowed only if the Federal government finds that the new state system is at least as cost-efficient as the national, Medicare-only DRG plan. If it is not, subsequent Medicare payments can be reduced by that amount.

The law also requires: (1) an annual report to Congress on the impact of a Medicare-only prospective payment system; and (2) a report by January 1985 describing the full extent of cost shifting and the feasibility of implementing a prospective payment for all payers.

**"Fair Payment" is not a theory.
It is actually working in several states.**

Maryland and New Jersey have had state prospective systems in place for several years and have experienced a rate of increase in hospital expenses below the nationwide rate. Maryland's system is centered around the Maryland Health Services Review Commission, which reviews and approves budgets for all hospitals in the state. Maryland reduced its average cost-per-admission from 20.5 percent above the national average in 1977 to 5.3 percent above in 1983.

New Jersey's system is based on DRGs that apply to all patients, unlike the Federal government's Medicare-only DRG plan. There, hospitals have reported price increases almost five percent lower than the national average. Indeed, during the period 1980 through 1982, New Jersey's rate of increase was the 48th lowest of all states.

Massachusetts and New York established cost containment programs in 1983. A preliminary report from the Massachusetts Hospital Association shows that the all-payer system in that

state has slowed the inflation of costs to 8.8 percent in fiscal 1983, down from 15 percent in 1982. Maine, West Virginia, Washington and Connecticut are the latest states to pass legislation to allow the establishment of prospective payment systems, and similar proposals are pending in a number of other states.

One of the attractive features of the existing all-payer systems is their flexibility. They operate quite differently from each other, reflecting the needs of the particular state.

What Can You Do?

It is not yet known whether prospective payment will achieve all that is hoped in reforming the hospital payment system and controlling health care costs. It is, after all, too new.

One thing, however, is known—we must all work together to control costs. How can community and consumer leaders help? Business leaders in several states have formed health care coalitions. They meet regularly to discuss specific action plans and welcome consumer input.

Another step would be to examine any "Fair Payment" bill in your state legislature designed to apply prospective payment to all payers and determine if your organization should support the bill. This action would be a major step forward toward solving the cost shifting problem and containing the costs of health care.

Other initiatives include pressing for hospital price information, the posting of doctors' fees and the sponsoring of wellness programs and good health campaigns in your community.

Find out how you and your organization can contribute to controlling health care costs in your state, town or community. It's in everyone's best interest to get involved.

For further information about this newsletter, please contact:

Shawn Hausman
Public Relations Division
Health Insurance Association of America
1850 K Street, NW
Washington, DC 20006-2284

EXHIBIT I-A

Reasons for Rising Health Care Costs

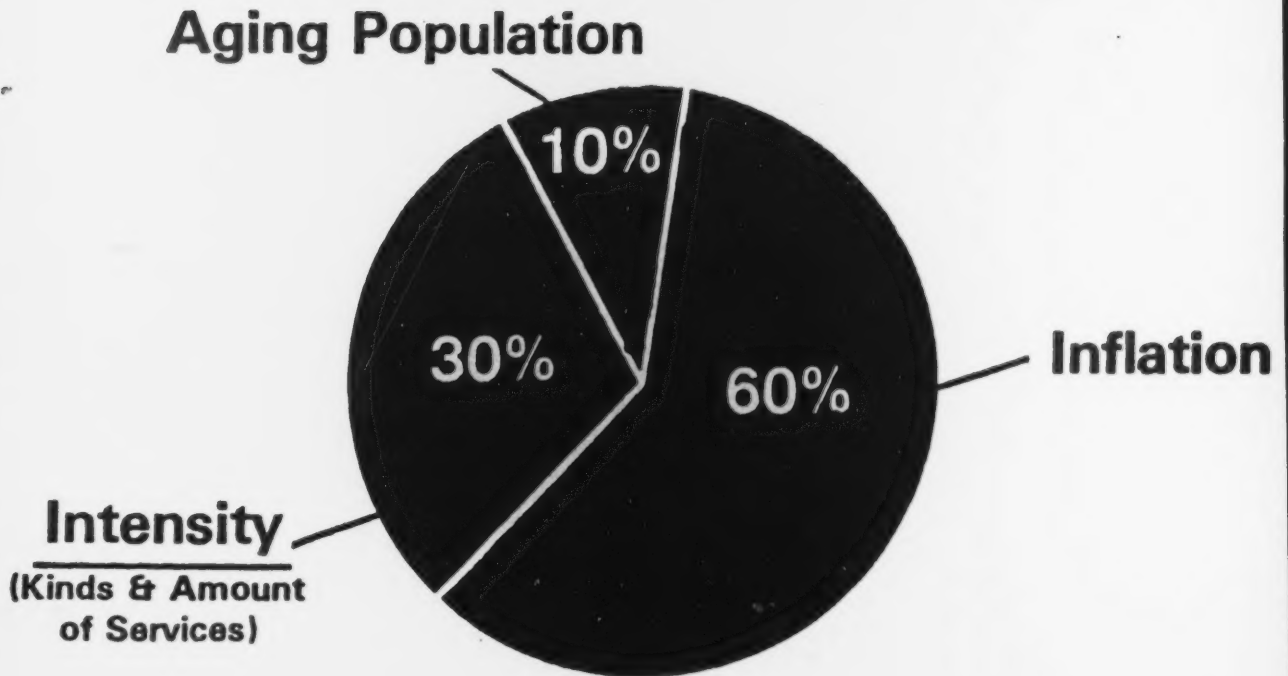
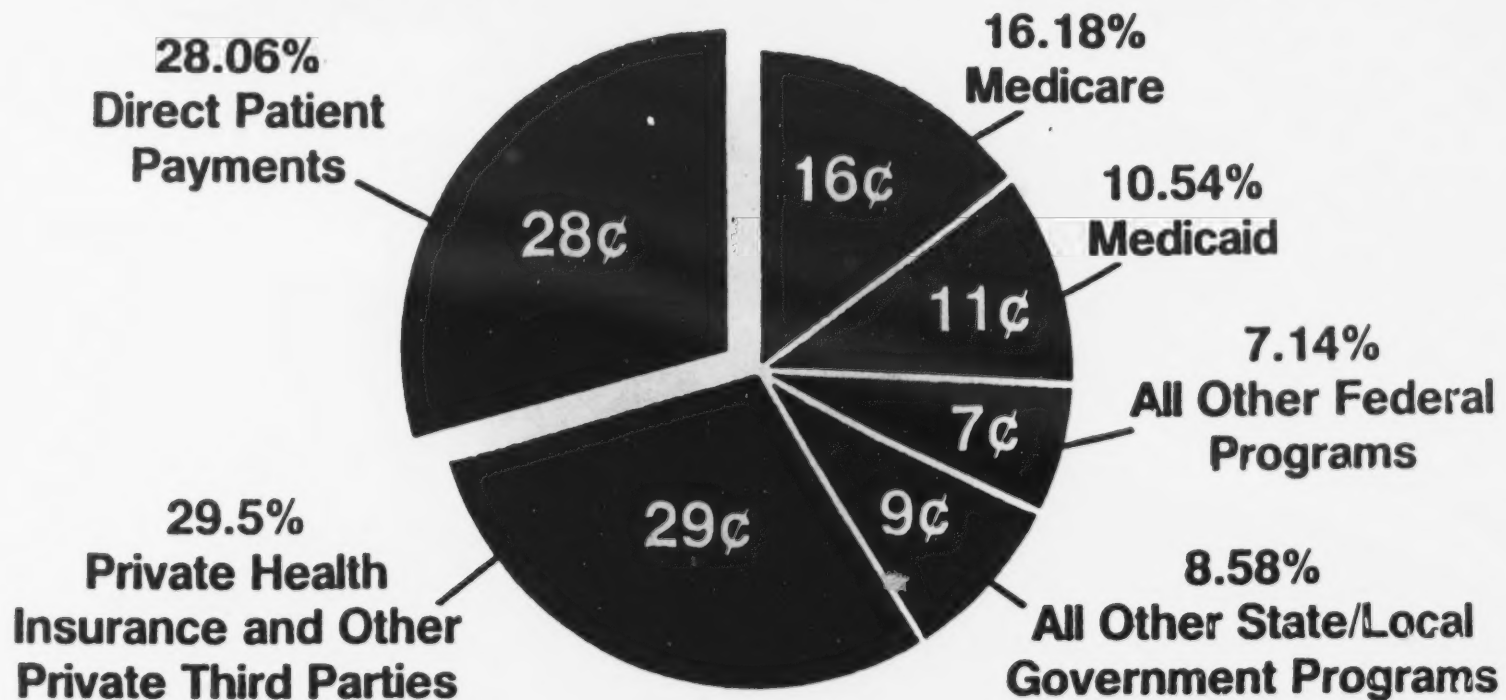


EXHIBIT I-B

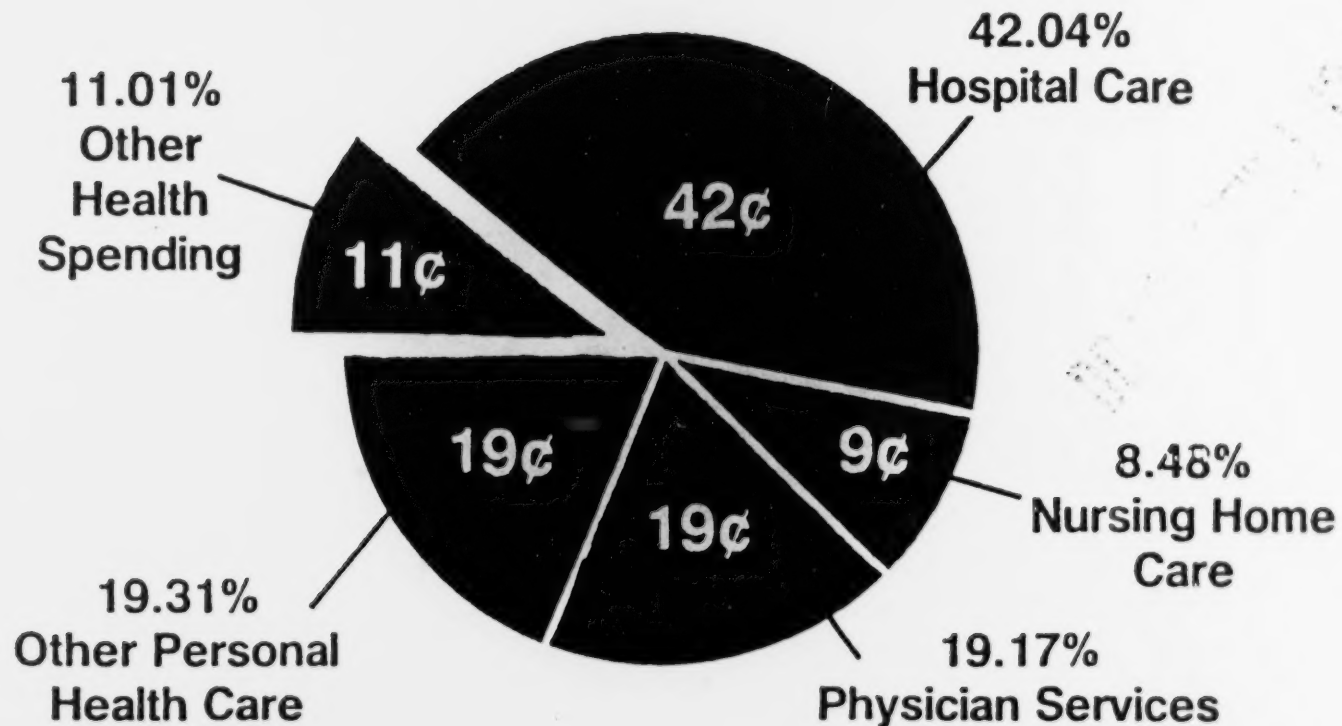
Nation's Health Dollar in 1982 Where it Came From



Source: Bureau of Data Management and Strategy, Health Care Financing Administration

Nation's Health Care Dollar in 1982

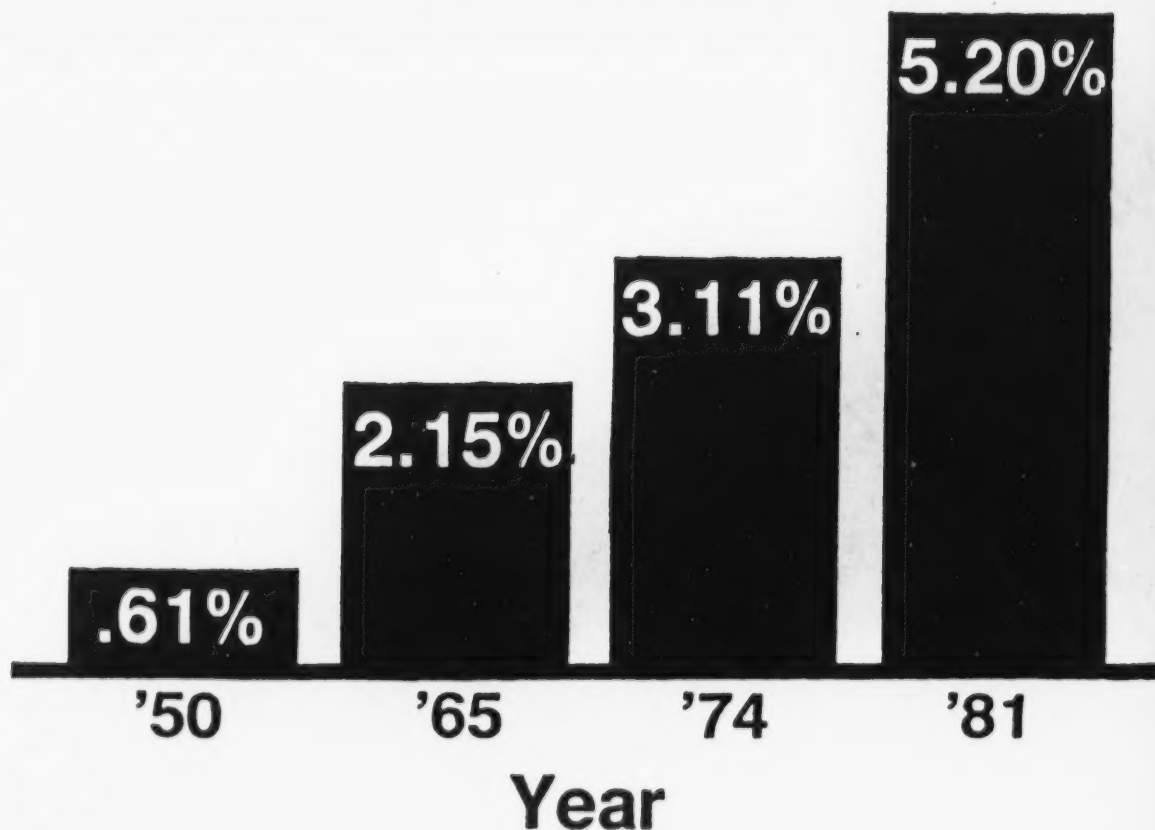
Where it Went



Source: Bureau of Data Management and Strategy, Health Care Financing Administration

EXHIBIT I-D

Health Insurance Costs As Percent of Payroll (1950-1982)



LEADER TEACHING GUIDE

I. OVERVIEW

B. MAJOR TRENDS -- CHANGES CONSUMERS CAN EXPECT IN HOW HEALTH CARE IS DELIVERED, USED, AND PAID FOR

Lesson Outline

Suggested Learning Activities

- I. Recently skyrocketing prices have caused changes in the health care delivery system to decrease costs. Employers have also initiated cost containment measures. Some of these trends include:
 - A. More out-patient procedures.
 - B. Growth of Health Maintenance Organizations (HMOs), Independent Practice Associations (IPAs), and Preferred Provider Organizations (PPOs).
 - C. Increased competition between health care providers.
 - D. Use of Prospective Payment (fixed price) system of payment for services based on Diagnosis-Related Groups (DRGs).
 - E. Growth of Health Promotion/Disease Prevention and Wellness Programs.
 - F. Reduction of tax breaks for medical expenses.
 - G. Less first dollar 100% insurance coverage - increase in comprehensive major medical and co-insurance.
 - H. Growth of large, integrated health care companies.
 - I. Increase in self-insurance by business.
 - J. New rules governing how consumers can use their health care coverage, such as pre-admission certification and second opinion prior to surgery.

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review Changes In Health Care: What You and Your Family Should Know. Individuals may request a free copy from The Ohio State Medical Association by calling 1-800-MED-NEWS (1-800-633-6397).

Brainstorm with class (in small groups or as a whole) on trends--compile list; add omissions using Exhibit I-E - "Health Care Trends In Next Decade."

Changes

in

Health Care:

What you and your
family should know...

A Message from Ohio's Physicians

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A message sponsored by the physician members of
The Ohio State Medical Association
600 S. High Street
Columbus, Ohio 43215
(614) 228-6971

Changes In Health Care

A lot of changes are taking place in health care today—changes which will affect the way you and your family **receive** your health care and the way you **pay** for it.

Employers, insurance companies, and other third party payors, including the government, are changing the way health care is provided and the way costs are reimbursed. People are being confronted with new health benefits options, bearing names such as HMO, IPA, PPO. Yet, in research it conducted in early 1985, the Ohio State Medical Association found that people are confused about what these options will mean for their health. It found that people have questions about why things are changing and how these changes will affect the quality of medical care. They are concerned that some groups, such as the poor and the elderly, may not be able to get care. They worry about who will decide who gets care—and who doesn't—in the future; and they want to know how they, as individuals, can protect themselves and their families in these changing times.

That's why the physicians of the Ohio State Medical Association are sponsoring this booklet—to help you understand the changes taking place in health and to provide you with timely, factual information so you can make better health care decisions for you and your family.

Specifically, this booklet is designed to:

- **let you know some of the reasons behind the changes in health care;**
- **define the various health care options and help you decide which one's best for you;**
- **help you understand some of the major issues facing medicine in the future—issues such as the professional liability crisis and rationing of health care; and,**
- **let you know that the physicians of Ohio, while they are concerned about the cost of health care, will not allow quality of health care to be sacrificed in the battle to control costs.**

We hope you'll take the time to read through this booklet carefully. If you have any questions about any of the subjects mentioned, we encourage you to contact the Ohio State Medical Association at the address and telephone number listed in the back of this booklet.

Or better yet, ask your physician. He or she is the best person to help you understand what's happening in medicine today and to assist you in making decisions that are best for you and your family.

Why Health Care Is Changing

There have always been changes and experimentation in the health system. Experiments which have been conducted over the years have produced new technology, new medications and new ways of diagnosing improved quality of life for almost all Americans.

In a sense, the health care system is a victim of its own success. **More advances have been made in medicine in the past thirty years than in the past thirty centuries.** In one short lifetime, we have eradicated smallpox, polio and most other childhood diseases. Infant mortality has been reduced dramatically and life spans have increased by nearly ten years. We can now transplant not only human, but artificial parts of the body, restoring the ability to walk, to see, to hear, and to talk. But these advances have exacted a toll. They have added significantly to the nation's health care bill.

As a result, today many of the experiments being conducted in medicine aren't being done in the laboratory. They are being done in the board rooms of large corporations, and in the chambers of various government agencies. They have nothing to do with discovering new ways of treating disease. Rather they are being conducted in the areas of health care delivery and health financing. These experiments are being conducted for one reason and one reason alone: to lower health care costs.

Whether or not changes in delivery and financing will be able to control health care costs remains to be seen. Although physicians are concerned about costs, they fear that in the push to control health care costs, changes may occur which threaten the quality of medical care. For that reason, physicians are carefully monitoring these experiments to make certain they do not compromise either quality or access to care.

How Health Care Is Changing

Fee-for-Service

Most of the changes taking place in health care have to do with the way you pay for your medical care.

Today, most health care is still delivered in the traditional fee-for-service basis. Under such a system, your physician charges you a fee for the services provided to you. You, in turn, are responsible for paying the bill. **A fee-for-service system allows your physician the flexibility to provide the care that you need on an individual basis. You pay only for the care you receive.** Under this system, fees are usually determined by the physician based upon what is usual and customary in his or her geographic location.

With the advent of health insurance plans some 40 years ago, patients were relieved of some of the burden of paying for the total cost of their medical care out-of-pocket. You could enter into an agreement with an insurance company in which you would pay the insurance company a set fee, or premium, and the insurance company would pay the physician's fee. Although based on a fee-for-service system, the introduction of insurance into the system helped promote access to medical care by spreading the costs among a large group of individuals. Most health care is still delivered by this method today.

New health care plans, in an attempt to lower costs, combine both the delivery of health care (visits to the physician and the hospital) with the financing of health care (insurance reimbursement). In other words, with the new systems, medical services and insurance coverage are provided by the same organization. This organization is usually contracted by an employer.

Because so many delivery and payment mechanisms are being tested today, it would be impossible in the space of a short booklet to discuss them all. The following is a review of the major ones.

HMO

In general, an HMO (a health maintenance organization) is an organization that provides comprehensive health care services to a specified group of pre-paid members or subscribers. Membership in an HMO is based on a monthly, pre-paid fee, which is the same regardless of the amount of health care used. That fee may be paid by you, the patient, or it may be paid, in part or full, by your employer, the government or some other sponsor.

In its traditional form called the "staff model," HMO services are offered at a specific location(s) or facility(s) by a group of physicians and other health care personnel hired on a full-time basis by the organization.

The HMO may also contract with area specialists and hospitals for services not provided within its own facility(s), or it may have its own hospital and specialists on staff.

Most staff model HMOs require that you use their facilities and personnel exclusively, or the cost of your treatment will not be paid by the HMO. In an emergency situation you may be able to use another facility, but the HMO usually retains the right to review the visit to determine if it was a true emergency. You may also be asked by the HMO to call ahead for a telephone consultation before you come in for care, in order to determine whether or not your problem merits a personal visit. In addition, you may first have to be examined by an allied health practitioner, a nurse practitioner or a physician assistant, who often decides whether or not your condition warrants seeing a physician.

If the services of a specialist, such as an ophthalmologist (eye) or cardiologist (heart) are required, you may first have to be evaluated by an HMO staff member who will then refer you to a specialist within the HMO or under special contract with the HMO. Any form of elective surgery or non-emergency treatment requiring hospitalization also generally must first be approved by the HMO, or payment cannot be guaranteed.

Joining most staff-model HMOs limits your available choices of health care providers. The benefit for employers or sponsors, however, is that by maintaining regular facilities, carefully monitoring patients' need for and access to care, and keeping physicians on staff or under contract, the HMO may be able to contain the health care costs of the group. In addition, employers are better able to budget for health care, since they pay a set monthly fee, regardless of the amount of care given.

IPA

An independent practice association is a type of HMO. However, instead of working out of an HMO facility, IPA physicians practice out of their own offices. IPAs are generally formed and run by physicians who enter into agreements with other organizations, usually an employer, to provide medical services to a defined population. IPA physicians continue to see their regular patients on a fee-for-service basis.

PPO

Preferred provider organizations vary in type, but the most basic form of PPO is a group of health care providers (physicians and hospitals) who agree to provide services to a specific pool of patients (usually employment-based groups) at an agreed-upon rate. This rate usually is lower than the rate that the physicians and/or hospitals usually charge. Because of this discount, these physicians and hospitals are designated "preferred providers" by the organizing group. Patients who opt to utilize the "preferred providers" usually have their costs covered in full. Patients are allowed to utilize health care providers who are not "preferred providers"; however, then they are usually responsible for at least a portion of the costs.

A Word of Caution

As with many health insurance plans, HMOs, PPOs, and IPAs often are offered to consumers through their places of employment. Contracts for HMOs, PPOs, and IPAs are often negotiated by the employer and then offered as options to employees.

It is important to keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered to you today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any of these plans, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the benefits and restrictions of each option and read it carefully. Then, before making a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you eventually select.

Get the Facts Before You Sign

There are several questions you should ask before making any changes in the way you receive or pay for your medical care. Here is a handy checklist of questions you should make certain to have answered before you sign on the dotted line:

CHOICE OF PROVIDER: May I choose my physician or will one be assigned to me? Can I change physicians? Am I guaranteed that I will see a physician every time I come in for a visit? If I need a specialist, will my physician or I be free to choose one? Will care from the specialist of my choice be covered under the plan? What restrictions does the plan put on my ability to go to the hospital of my choice?

FACILITIES: If it is an HMO, how many facilities does the HMO have in the community and where are they located? What are their hours and how are they equipped? If I need care after hours or care that is not provided within HMO facilities, where can I go for help and who will pay for it?

EMERGENCIES: What happens if I become sick or injured out of town? What is considered an emergency? Who decides whether or not I will be reimbursed for emergency care given outside the group I am under contract with and how is this determined?

LIMITATIONS: How often may I schedule appointments for routine care? Am I limited in the number and type of visits, diagnostic procedures or hospitalization per year? Am I responsible for any costs above the monthly fees?

SECOND OPINIONS: If I disagree with the opinion of the physician or staff member I am under contract with, may I request a second opinion from an outside physician? If so, will I have to pay for it?

WAITING TIME: How far in advance must I schedule an appointment for routine care? How long should I expect to wait for care if I do not have an appointment?

TERMINATION: Can I be dropped involuntarily from the plan? What happens if the group goes out of business? How difficult is it to drop out of the plan and resume traditional insurance coverage?

TYPES OF SERVICES: What types of services will this plan provide for me and my family? Are there extras which I can add to the plan, and if so, how much will these extras cost?

COST: How much is my deductible, my premiums? What services are covered by this charge?

Other Innovations in Health Care

DRG

Although HMOs, IPAs, and PPOs combine delivery and payment methods, several other experiments are taking place in health care in an effort to curb costs in specific areas. Among the most visible of these experiments is the Diagnosis-Related Group (DRG).

DRGs, initiated by the federal government on October 1, 1983, are a revolutionary change in the way the government pays hospitals under Medicare. Prior to October 1, hospitals were paid retrospectively, after the fact, based on the actual cost of services provided by the hospital. Now, payment rates are determined prospectively, before the fact, based on a Diagnosis-Related Group.

Hospitalized Medicare patients are classified into one of 467 DRGs according to the diagnoses of their health problems and treatment required. A flat rate is paid for each DRG regardless of the length or intensity of treatment required, although some additional payment is permitted in extraordinary circumstances.

Most physicians, like most Americans, recognize the need to address the health care cost problem and are cooperating with hospitals to try to make the DRG system work. But physicians have some concerns about DRGs and the implications they will have on the future of health care in this country.

If the hospital's cost is less than the DRG rate, it keeps the difference. If it is more, the hospital takes the loss. The primary purpose of DRGs is to induce hospitals and physicians to reduce the cost of hospital care.

Most physicians, like most Americans, recognize the need to address the health care cost problem and are cooperating with hospitals to try to make the DRG system work. But physicians have some concerns about DRGs and the implications they will have on the future of health care in this country. Some of these concerns are:

- If DRG rates are too low, will hospitals and staff physicians be pressured to discharge some Medicare patients too early, before it's medically safe to do so?
- Will one result of this emphasis on predetermined cost and treatment levels result in a two-tiered medical care system: one for people not under DRGs and one for our elderly citizens?

- Will there be an incentive for hospitals to try and refuse or delay admission for Medicare patients with very serious or chronic health problems because the cost of treatment would be much greater than the amount set by the government and the hospital would lose money?
- Will hospitals that treat a large number of elderly and low or no-income patients be forced to close their doors because of insufficient DRG revenue?

These concerns are particularly important since there has been much discussion about extending the DRG payment system into other areas of health care beyond Medicare.

Although physicians are making every effort to cooperate with the DRG system, they will resist any effort which requires them to jeopardize a patient's health or sacrifice quality of care in the name of cost cutting.

Pre-admission Certification

In another attempt to lower the cost of health care, many insurance companies are now requiring some of their policy holders to get the insurance company's permission before being admitted to the hospital for non-emergency care. This is called Pre-admission Certification and has become much more prevalent in recent years.

Before a patient with this type of coverage is admitted to the hospital, his or her physician or the patient must contact the insurance company to get clearance for the admission. If permission is not obtained and the patient is admitted, the company may either refuse to pay or pay at a reduced level. Since the certification standards vary widely among insurance companies, the pre-admission certification requirements have caused a great amount of confusion among physicians and patients alike.

In addition to being an administrative nightmare, many physicians question the cost effectiveness of pre-admission certification and believe that the decision for a patient to be admitted to the hospital should be between the patient and his or her physician-not an insurance company.

Issues Facing Medicine

In addition to specific changes in medical care financing and delivery, several other issues will have a dramatic effect on the cost of medical care in the future and the way it is provided. Among the most critical are: environmental trends, professional liability, rationing of medical care, advances in technology, and competition in health care.

Environmental Trends

Among the most important of the environmental trends facing medicine today is that of an aging population. By the year 2000, a scant 15 years from now, more than 100,000 individuals in the U.S. will be over age 100. Twice that many will be over age 85 and the biggest segment of the population, the baby boomers, will be in their late 50s. Historically, the elderly consume twice as many health care services and resources as other segments of the population and, on the whole, require more intensive, more expensive, continuing medical care. Paying for, delivering, and maintaining the quality of that care will be one of medicine's greatest challenges in the years to come. And it will give rise to some crucial social questions in terms of expenditure of our medical resources on an elderly population.

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Professional Liability

Professional liability, often called malpractice, isn't just a physician problem. It is a problem that affects **everyone**. It is adding dramatically to the cost of medical care, and, as the problem continues to grow, it is beginning to threaten both access and quality of medical care. One indication of the seriousness of the problem is the staggering increase in lawsuits and in awards. Nationwide, the number of malpractice lawsuits filed has tripled in the past five years. Likewise, the average settlement in a malpractice case has sky-rocketed.

The cost of insurance is the fastest growing part of a physician's cost of practicing medicine. Physicians now routinely pay as much as \$20,000 to \$30,000 a year in premiums for professional liability insurance, and in some areas of the country and in some specialties, as much as \$80,000 in premiums.

In 1982, physicians paid a total of \$1.43 billion in premiums for professional liability policies. As in any business, some of that cost is passed along to you. Every time you set foot into a doctor's office, climb into a hospital bed or have surgery, you are paying part of that cost.

There are indirect costs as well. To protect themselves from lawsuits, physicians find they must practice what is known as "defensive medicine"; that is, they must order additional tests and perform additional procedures in order to protect and defend themselves should a lawsuit be filed. The cost of defensive medicine has been estimated to add between \$15 to \$40 billion a year to our nation's cost of health care.

Again, much of that cost is being passed along to you, the patient.

In 1982, physicians paid a total of \$1.43 billion in premiums for professional liability policies. As in any business, some of that cost is passed along to you. Every time you set foot into a doctor's office, climb into a hospital bed or have surgery, you are paying part of that cost.

Although not as visible as costs, but no less important, is the threat to both quality and access. Statistics show that it is often the most highly skilled physicians who are sued for malpractice. These are the physicians who treat the high risk patients, perform the most delicate surgeries, and utilize the most advanced technology and procedures. If a patient or procedure is high risk to begin with, the possibility of something happening which is out of the physician's control also increases. If something does happen and the patient is dissatisfied, he or she may file a lawsuit.

Because of this threat, many physicians are leaving areas of medicine where they are needed most. This, in turn, creates an access and quality problem for the patient. If fewer physicians are willing to attempt difficult procedures, it means that fewer high risk patients will be able to receive the care they need. Long-term, this will result in a reduction in quality of care, which may lead to an eventual slowing down of progress in medical treatment.

Today, we are able to transplant hearts, kidneys, and livers successfully, only because patients and physicians are willing to take the risk. If the personal risk becomes too great, we may see a decrease in the number of physicians performing these procedures.

To protect themselves from lawsuits, physicians find they must practice what is known as "defensive medicine"; that is, they must order additional tests and perform additional procedures in order to protect and defend themselves should a lawsuit be filed. The cost of defensive medicine has been estimated to add between \$15 to \$40 billion a year to our nation's cost of health care.

It is ironic that this crisis in professional liability is occurring in a time when the future of medicine holds so much promise. New technology is helping to save lives that 10 years ago would have been lost. But these vast improvements in medicine have created unrealistic expectations that every medical service will produce perfect results. There is a trend in the courts toward holding physicians and hospitals liable for outcomes over which they have no control.

No one denies that malpractice occurs. Mistakes occur in medicine just as they do in our legal system, in government, and in other service professions. Physicians would never deny any patient the right to file a legitimate claim and be compensated for harm suffered because of a negligent doctor.

But the vast majority of the claims being filed are not against "bad doctors." The sky-rocketing number of professional liability cases filed each year and the astounding increases in awards are a result, in part, of a misuse of the legal system.

It is apparent that changes must be made in the way in which we, as a society, define liability and pay for it. One method might be to place a ceiling on the amount of damages awarded in malpractice cases. The research conducted recently by the OSMA indicated strong support among consumers for such action.

In addition, there should be a restructuring of the legal system to ensure that claims are resolved efficiently and that fair and adequate compensation is available for injuries arising from true medical negligence. Finally, there must be protection from suits which lack merit so that quality, access to care, and cost to the patients are not negatively affected.

Physicians must do their part by improving communications with patients so that expectations can be discussed and misunderstandings resolved. And patients must learn to speak up when confronted with a situation they don't understand.

Rationing of Medical Care

The rationing of medical care is frightening and abhorrent to most of us. Most people believe that equal access to medical care is a basic human right and must be maintained regardless of age, level of need, or ability to pay. Each person is equal and each life as sacred as the next.

This belief has led us to spend millions each year to maintain emergency squads just in case one person needs it. We allocate millions of dollars each year for medical research which we believe will someday save lives and improve the quality of life. And over the past two decades, we have spent billions of our tax dollars on government health care programs in a societal effort to ensure that no one in need is denied medical care.

Yet today, as cost pressures begin to mount, we find we must now take economic issues into consideration. Increasing health care costs have given rise to some very painful questions; if we believe that access to medical care is a basic human right, but that we are spending too much for it, how then are we to provide it? How much can we afford to spend on medical care as opposed to defense, education, and social welfare programs? Should a different level of service be offered to those who cannot pay or who are above a certain age? Who should decide who benefits from new technology and who doesn't? As our society ages, our technology improves, and our ability to prolong life increases, who will decide who gets care, how much and at what price?

Increasing health care costs have given rise to some very painful questions; if we believe that access to medical care is a basic human right, but that we are spending too much for it, how then are we to provide it? How much can we afford to spend on medical care as opposed to defense, education, and social welfare programs? Should a different level of service be offered to those who cannot pay or who are above a certain age? Who should decide who benefits from new technology and who doesn't?

These are just a few of the difficult questions facing medicine today. Yet some experts have suggested that there is no real cost crisis in health care, but rather a crisis in terms of how much we want to spend and how we're going to distribute the costs.

To illustrate their point, the experts list several factors:

- Four million of the 20 million new jobs created in the 1970s, or one out of five, were in health care. Many of these jobs went to women and minorities.
- The amount spent on health care in the U.S. (12% of the gross national product) is not out of line with that spent in other Western countries, where it generally ranges from eight (8%) to twelve (12%).
- The U.S. has one of the lowest infant mortality rates, one of the longest life spans, and enjoys one of the highest levels of health of any country in the world.
- More is spent in this country on alcohol and tobacco (\$60 million) than is spent on cancer research.

...some experts have suggested that there is no real cost crisis in health care, but rather a crisis in terms of how much we want to spend and how we're going to distribute the costs.

These same experts point out that a price must be paid for health care. It may be in terms of more dollars pumped into the system, it may mean establishing restriction in terms of access for some groups, or it may mean a reduction in our expectations as to quality of care. But eventually, a price must be paid and only society can decide how to pay it.

Improvements in Technology

Experts agree that changes in medical technology will be one of the most important forces for change in medicine. Advances in technology will cause dramatic shifts in demand for medical care. They will contribute to increased costs in some areas and decreased costs in others. Generally, these advances are expected to improve the overall quality of health care and result in a further increase in life expectancy. Improvements in technology can be expected in the areas of artificial organ transplants, ultrasound, CT scanning, laser surgery, drug therapy, and immunizations. Although they may lead to an eventual decrease in cost, these advances will be expensive to develop and will be in great demand, giving rise, again, to questions regarding cost and access.

Competition in Health Care

Until recently, competition was not a concept people associated with health care. Neither hospitals nor physicians had to compete for patients. There were plenty of patients, adequate resources, and more than enough work to go around. Today, competition has taken center stage in health care. No single phenomenon will affect health care more radically in the future than will the specter of increasing competition.

And, as hospitals, physicians and other health care providers vie for their share of the marketplace, people will find themselves faced with increasing options. Competition will begin to resemble traditional business markets. This is of concern to many physicians who fear that in the rush to provide as much care as possible to as many patients as possible at the lowest price possible, quality of care may suffer. To protect against this possibility, physicians are carefully monitoring the competitive practices being set in motion today.

A Final Word

Just a few short years ago, the relationship between physician and patient was a relatively simple and informal one. The patient selected the physician based on a personalized set of criteria: past experience, recommendation of a friend or relative, convenience, referral by another physician, reputation, etc. Care was provided as requested by the patient and a fee was paid as determined by the physician. Today, for a wide variety of reasons, mostly related to cost containment, the relationship is changing. Third parties, government and insurance companies, rather than patients, pay the direct costs of medical care. They, in turn, are paid by business, industry and individuals in the form of insurance premiums. As these premiums have risen, those who pay the bills have sought ways to cut costs. Today, two of the most common cost-cutting procedures are competition and regulation, and both procedures have given rise to new methods of delivery and new financing mechanisms.

Caught in the middle of this shifting environment is the consumer who finds that this simple physician-patient relationship has evolved into a system of conflicting and often confusing options.

What can you, as a consumer of health care, do to ensure that you and your family receive quality medical care at an affordable price?

- **First**, and most important, is to establish an ongoing relationship with a personal physician. He or she will be able to provide you with information that will help you make better choices about your health care. In case of an emergency, your physician can be available to provide necessary care or important information which may save your life. Your personal physician can serve as the coordinator of your care should you require hospitalization or the service of a specialist.
- **Second**, don't be afraid to ask questions about anything you don't understand, whether it's the cost of your treatment or questions about your diagnosis. It is in the best interest of both you and your physician that you have a clear and accurate picture about how your care is being delivered.
- **Third**, take an active role in maintaining your own health. Practice a healthy lifestyle, follow your physician's instructions, recognize danger signals which may result in a health problem, and seek care early if you feel you may have a problem. Many conditions such as cancer and heart disease can be treated and, in many cases, cured, if treatment is sought early.
- **Fourth**, take time to enjoy life. Experts agree that more than half of all visits to the physician are by the worried well. Stress, strain and anxiety can lead to a number of physical ailments. Learning to recognize and cope with life's stresses can help to maintain your health and improve your quality of life.

Questions to Ask In Choosing Your Physician

An open and honest relationship between you and your physician is vital to your good health care. Although many physicians provide patients with a booklet which outlines their office policies and procedures, when choosing a physician you will want to make certain to have answers to all of the following questions:

- 1) Must I have an appointment when I need to see you?
- 2) How long will I have to wait for an appointment?
- 3) What should I do in case of an emergency?
- 4) What are your office hours?
- 5) Are you a member of the health plan I belong to?
- 6) How must I pay for care?
- 7) Do you assist in completing and filing insurance claim forms?
- 8) Will I see you each time I have an appointment or will other physicians in the practice see me?
- 9) If I need hospitalization, which hospital will I be admitted to?
- 10) If I need a specialist, will you assist me in finding one?
- 11) Will you answer questions over the telephone?

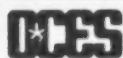
EXHIBIT I-E

HEALTH CARE TRENDS IN
THE 1980'S

- MORE OUTPATIENT PROCEDURES.
- GROWTH OF ALTERNATIVE DELIVERY SYSTEMS. (HMOs, IPAs, and PPOs)
- INCREASE IN COMPETITION BETWEEN HEALTH CARE PROVIDERS.
- USE OF PROSPECTIVE PAYMENT (Fixed Price) SYSTEM OF PAYMENT FOR SERVICES BASED ON DIAGNOSIS-RELATED GROUPS (DRGs).
- GROWTH OF HEALTH PROMOTION/DISEASE PREVENTION AND WELLNESS PROGRAMS.
- REDUCTION OF TAX BREAKS FOR MEDICAL EXPENSES.
- LESS FIRST DOLLAR 100% INSURANCE COVERAGE -- MORE COMPREHENSIVE MAJOR MEDICAL AND CO-INSURANCE.
- GROWTH OF LARGE, INTEGRATED HEALTH-CARE COMPANIES.
- INCREASE IN SELF-INSURANCE BY BUSINESS.
- NEW RULES ON HOW HEALTH CARE COVERAGE IS USED (e.g. Pre-admission Certification and second opinion prior to surgery).



Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



II. MATCHING HEALTH CARE NEEDS WITH OPTIONS FOR COVERAGE

This section is designed to assist individuals and families in assessing their health care needs while providing examples of several types and sources of health care coverage which may meet those needs.

CONSUMER OBJECTIVES:

After completion of this section of leader training, participants should be able to:

1. List three factors in assessing health care needs and cite at least one personal example.
2. Describe two different types of health care coverage available.
3. Identify three possible sources of health care coverage.

Prepared by Lindell C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service.
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II. MATCHING HEALTH CARE NEEDS WITH
OPTIONS FOR COVERAGE

A. ASSESSING HEALTH CARE NEEDS

Lesson Outline

Suggested
Learning Activities

- I. Major factors in determining how much health care coverage is needed:

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

A. Past health history.

1. How many illnesses or a chronic health problem?

Review fact sheet "How Much Health Insurance Do You Need?"

Design a mini-lecture using lecture outline at left. Display and discuss Exhibit II-A - "Assessing Health Care Needs" (may be made into a transparency).

2. What medical expenses have been incurred in past 2-3 years?

Accurate records are critical. Suggest ways to promote record keeping (i.e., tax record book).

B. Stage in Family Life Cycle.

1. Young Adulthood (single)
Need insurance at about age 19 unless full-time students are covered in family's plan.
2. Married
- a. Add coverage for pregnancy and childbirth in advance of needing it (plans often exclude maternity benefits for first 9-12 months).
- b. Coverage for newborns should start at birth.
- c. Determine if well-child care (i.e., check-ups and immunizations) are covered.

Review "Health Care Coverage...When You Are Not In A Group" which describes P.L. 99-272 which affects children losing group coverage due to age.

List the stages in the Family Life Cycle on board or flip chart. Brainstorm on specific needs of each group:

3. Pre-retirement (up to age 64)

- a. Keep coverage up-to-date, especially if changes such as:

- (1) New job
- (2) Increase in family size.
- (3) Divorce or death of spouse.

- b. How well health habits are being maintained impacts on present and future needs for coverage.

4. Working: Ages 65-69

- a. Under TEFRA (Tax Equity and Fiscal Responsibility Act of 1982) employers with 20 or more employees must offer to continue employee and spouse on company health plan. Employee must choose plan or Medicare as the primary insurer.

- b. If covered under company health plan, working persons may choose to delay taking Part B of Medicare (monthly premium in 1987 is \$17.90) until retirement without a penalty or waiting for yearly enrollment period.

- c. Coverage can be split between spouses.

5. Retired.

- a. Expenses paid by consumer under Medicare rising annually (i.e., deductible as of January 1, 1987, is \$520). If Medicare is only protection, need to decide whether to buy Medigap insurance.

Review "Health Care Coverage...When You Are Not In A Group" for federal law, P.L. 99-272, which covers persons losing group coverage due to divorce, death of spouse or lay-off.

For more information, read Staying Well - Your Responsibility.

Additional free copies are available from:

Health Insurance Assoc.

of America

1850 K Street, NW

Washington, D.C.

20006-2284.

Review "Employed Medicare Beneficiaries Age 65 Through 69."

Explain option; ask students to debate pros and cons of each choice. Stress need to evaluate which coverage would be best and whether paying for Part B is worthwhile.

For more information, refer to "Health Insurance: A Crucial New Choice For Older Workers." Changing Times, November, 1983, p. 70.

C. Future Health Requirements

1. Are there unusual health hazards associated with a family member's job, community, or life style.
2. Will special surgery for a chronic problem be quired?
3. Are there special needs such as allergies or emotional problems which require testing or treatment.
4. Is the family's genetic history such that they are at a greater risk of developing an expensive illness which would require extended coverage under a major medical policy?

Ask students to list 3 examples of health hazards.

Ask for an example of a chronic problem and/or examples of special conditions which require on-going attention.

Ask students to cite examples of several genetic disorders.

5. Consider today's average life span. Many family members today tend to live well into old age, there may be a need to purchase major medical well before retirement and/or some form of protection for extended care.

D. How Much Can You Afford?

1. Determine how much money is available for medical costs. Can flexible expenses be reduced to free up money for medical costs or insurance.
2. Absorbing some medical expenses (through a higher deductible) can save money on premiums.

Duplicate and distribute "Expense Work Sheet." Participants can complete this after the workshop.

If the family needs help with budgeting, suggest they call the Cuyahoga County Extension office at 631-1890 and request help through the Family Budget Counselors program. This service provides one-to-one counseling by a trained Family Budget Counselor free of charge.

3. Determine how much hospitals and doctors in the area charge.

Ask several volunteers to check with local hospitals and report at next meeting, or see if any participants have current knowledge about hospital costs.

4. Do you qualify for any free or low-cost medical treatment?

Refer participants to: Free and Low-Cost Medical Resources in Cuyahoga County published by the Cuyahoga County Public Library (copy enclosed) or refer participants to: Health Lines 1986 Directory of Cleveland Health Services available free from the Office of Community Health, Case Western Reserve University, School of Medicine, 2119 Abington Road, Cleveland, OH 44106, 216-368-3660.

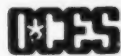
E. Determine Current Level Of Protection.

1. Benefits may be available from a number of sources:
 - a. Private insurance
 - b. Employer provided benefits
 - c. Disability insurance
 - d. Workers' Compensation
 - e. Social Security
 - f. Liability insurance
 - g. Life insurance

Duplicate and distribute "Health Care Coverage Needs Assessment Survey." Allow time for participants to complete survey based on their own needs or ask them to complete it at home for themselves or a family member or friend.



Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



SECTION II-A

HOW MUCH HEALTH INSURANCE DO YOU NEED?

There is no simple formula for determining the exact amount of insurance an individual or family should have. In general, the best program is one that prevents undue financial strain from an unexpected illness or injury--and is not too expensive to maintain. In assessing your need for protection, take these factors into consideration.

PAST HEALTH HISTORY

Has the family had many or few illnesses?

Does a family member have a chronic health problem?

What were your medical expenses over the past few years?

STAGE IN THE FAMILY LIFE CYCLE

Single Young Adulthood - once children reach approximately age 19 (depending upon the plan) and are not full-time students, they will no longer be eligible to remain on the family's plan. If high premiums are keeping you from buying coverage, some experts suggest you look for a policy with a high deductible (\$500-\$2,500) to keep the premium payments as low as possible, or look into joining an HMO.

Married - you may now need to include pregnancy and childbirth coverage in your plan. Couples or single parents with dependent children may want well-child care for check-ups and immunizations. Be sure coverage includes all family members, including newborns from birth.

Pre-retirement (up to age 64) - Periodically review your coverage to be sure it is up-to-date, especially when your personal or financial position changes (i.e., new job, new baby, divorce). How well your health is being maintained is important to both present and future needs.

Working: Ages 65-69 - under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), Medicare beneficiaries and their spouses who continue to work (for employers of 20 or more) after age 65 must be offered the opportunity to remain under the current company health plan, with Medicare supplementing company benefits or to choose Medicare as the primary plan.

Retired - Medicare does not pay all medical bills, and lately it has required more and more expenses to be paid by the consumer. Many retired Americans are faced with the need to purchase supplemental insurance or consider other options, such as joining an HMO.

FUTURE HEALTH REQUIREMENTS

Are there any unusual health hazards associated with your job, life style, or community?

Is surgery a distinct possibility for a family member?

Does a family member have special needs such as allergies which may require testing and treatment?

Is a family member having drug, alcohol, or emotional problems which require the services of a special facility?

Does the family's genetic history place you at a greater risk of developing an expensive illness or condition which would require extended coverage under a major medical policy?

Consider today's average life span. Many family members today tend to live well into old age. Thus, there may be a need to purchase major medical well before retirement or some form of protection for extended care. Insurance companies are beginning to market nursing home policies which may or may not cover "custodial" care.

HOW MUCH YOU CAN AFFORD

Determine how much money is available for medical costs. Can flexible expenses be reduced to free up money for medical costs or insurance.

Absorbing some medical expenses (through a higher deductible) can save money on premiums.

Determine how much hospitals and doctors in the area charge.

WHAT PROTECTION YOU ALREADY HAVE

Before buying any health insurance, you need to know what benefits you or your spouse already have. Make sure you have up-to-date information. Group or individual policies that you already have should be studied. Check into benefits under Workers' Compensation, Social Security, the medical benefits under your liability insurance, and your life insurance disability provision. Only by knowing what protection you have can you decide whether you have too much, too little, or enough health care protection.

EXHIBIT II-A

ASSESSING HEALTH CARE NEEDS

MAJOR FACTORS IN DETERMINING
HOW MUCH HEALTH CARE COVERAGE IS NEEDED:

- PAST HEALTH HISTORY
- STAGE IN FAMILY LIFE CYCLE
 - ~ Young Adulthood
 - ~ Married
 - ~ Pre-retirement
 - ~ Working: Ages 65 - 69
 - ~ Retired
- FUTURE HEALTH REQUIREMENTS
- HOW MUCH YOU CAN AFFORD
- CURRENT LEVEL OF PROTECTION

mechanisms like health maintenance organizations, or use private health insurance. The coverage ends if premiums are not paid; if persons become eligible for other group coverage through employment, remarriage or Medicare; or if the employer ends group health insurance for all employees. In the case of a divorce, provision for health insurance may be included as part of a divorce decree; but remember that coverage ends if premiums are NOT paid, so consider paying the premiums yourself and be reimbursed by your former spouse. Otherwise, late or missed payments could jeopardize your coverage.

The law also provides that beneficiaries will have the right to convert to an individual policy when the time is up for group coverage to be offered. The coverage in **CONVERTED GROUP POLICIES** may be less thorough than the group policy and will probably cost more, but there is immediate coverage for pre-existing conditions.

HEALTH CARE COVERAGE ... When You Are Not in a Group

Prepared by Lindell C. Northup, Program Assistant,
as part of a Research and Training project of the
Cuyahoga County Cooperative Extension Service.

The Ohio State University, 6/86.



CUYAHOGA COUNTY COOPERATIVE EXTENSION SERVICE

3200 West 65 Street
Cleveland, Ohio 44102
216-631-1890

IN COOPERATION WITH

CLEVELAND METROPOLITAN GENERAL/ HIGHLAND VIEW HOSPITAL

3395 Scranton Road
Cleveland, Ohio 44109
216-398-6000



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HEALTH CARE COVERAGE ... When You Are Not in a Group



MAKING SENSE OF HEALTH CARE PLANS:

THE CONSUMER'S GUIDE TO
HEALTH CARE COVERAGE



CUYAHOGA COUNTY COOPERATIVE EXTENSION SERVICE
THE OHIO STATE UNIVERSITY

If you are not covered by a group health care plan through an employer, for example, consider some of the following steps:

- **SECURING GROUP COVERAGE THROUGH AN ORGANIZATION** such as a professional or fraternal society which you are eligible to join and which offers health insurance to its members. If you are 50 or over, look into groups which serve senior citizens.

- **CONSIDER JOINING A HEALTH MAINTENANCE ORGANIZATION (HMO).** Once you pay the monthly payments, out-of-pocket expenses are usually minimal and services include preventive (routine) health care. Open enrollment for individuals at most HMOs is once a year with no medical screening required.

- **A SPOUSE'S POLICY.** If either a husband or wife work and are covered by a group plan, a spouse often qualifies as a dependent under the other's policy. You may be required to pay a portion of the premium for family coverage, but the protection is usually worth the cost.

- **SELF-EMPLOYED OR EMPLOYEE GROUPS OF FEWER THAN 100 PEOPLE IN GREATER CLEVELAND** are eligible for group insurance through the Council of Smaller Enterprises

(COSE), a division of the Greater Cleveland Growth Association. Membership in COSE, including an annual fee, is required to apply for health care coverage. A variety of plans, including HMOs, a PPO and a supplement to Medicare are available, as is dental coverage, group life, and short and long term disability. The phone number for COSE is 621-3300.

- **INVESTIGATE FREE CARE FOR NON-COVERED PROBLEMS.** For example, if immunizations are not covered by your insurance, you may be able to get them free from your community health center. Also, free treatment may be available from community health centers that specialize in treating sexually transmitted diseases.

- **IF YOU ARE WITHOUT HEALTH INSURANCE,** refer to *Free or Inexpensive Medical Resources for Those Without Health Insurance*, published by the Information and Referral Service, Cuyahoga County Public Library, 6155 Engle Road, Brook Park, Ohio 44142, also available through county libraries or by calling 267-1563. This list contains numerous references to free or low-cost resources including mental health, medical and dental services.

If you are about to lose your group coverage provided through an employer due to:

- divorce
- death or retirement of a spouse
- unemployment
- reduced hours of work

... a new federal law which takes effect for health plan years beginning after July 1, 1986 may help you to temporarily continue your coverage. Public Law 99-272, requires employers to offer widows, divorced spouses, and Medicare-ineligible spouses of retiring workers covered by group health care plans, and their dependent children, the opportunity to continue health coverage for up to three years by paying the premium themselves. The law also requires that employers with group plans offer group coverage to laid-off or reduced-hour employees and their dependent children for up to 18 months. In addition, dependent children who become ineligible to remain on the family plan because of age are eligible to purchase group coverage in the same manner. In all cases, the employer can charge an extra 2% administrative fee.

The law applies to any private employer with 20 or more employees as well as state and local governments, whether they are "self-funded," provide coverage through

Staying Well—Your Responsibility

By Helen Leonard

Through the ages, the relationship between good health and a longer, happier life has always been recognized. But it was also recognized that maintaining good health isn't easy.

In more recent times, as medical discovery followed medical discovery, many health experts thought they had it figured out:

Spend enough money on modern medical techniques, educate the public to enlightened forms of hygiene, sanitation and immunization—and you could control disease, improve health, lengthen life.

To an extent, they were correct. People today are living better and longer.

So we must be on the right track. Just maintain the search for advances in medical science to make us even healthier and put ourselves in the hands of competent doctors after we get sick so they can make everything right. Right?

Wrong, say medical authorities. For from this point forward they have concluded it is not science but self-control that will add to our years.



A Matter of Lifestyle

It comes down to this: Most of us are born healthy and made sick as a result of personal behavior and environmental conditions. It's our lifestyle—basically, our failure to exercise enough, eat properly, take care of ourselves intelligently—that is the cause of many of our current health problems.

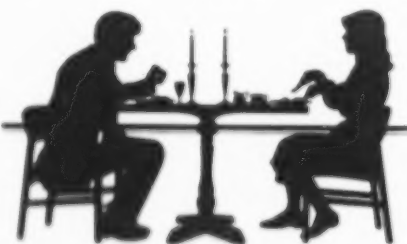
What should you do? There are some basic habits that can turn the odds for good health in your favor.

Proper Exercise

Make time on a regular basis for exercise, such as brisk walks, swimming, jumping rope, bicycling, or calisthenics.

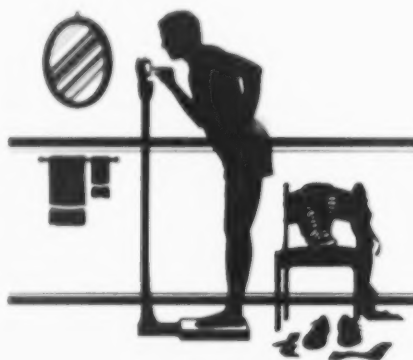
You can even find ways to exercise in your daily routine. You might try these:

- Take the stairs instead of the elevator. If you live or work in a high rise, walk a few flights of stairs before taking the elevator.
- Park your car a couple of blocks from your destination.
- Clothe yourself while standing up instead of sitting down. This is good for your balance and muscle control.
- Wash your car or work in your garden.
- Dance to music on the stereo or radio instead of watching TV.



A Good Diet

The body needs energy and nutrients periodically, and functions best when these are supplied regularly. When you snack, nutritionists suggest only fresh fruits and vegetables.



Also, to cut the risk of clogging your arteries, try to reduce the fats in your diet. That means substituting lean meats, chicken, fish and skimmed milk for fatty meats or whole milk products.

Cut down on your consumption of sugar and salt. No matter how little you think you consume, the experts tell us it is probably more than is necessary.

USDA Dietary Guidelines

- Eat a variety of foods.
- Maintain an ideal weight.
- Avoid too much fat, saturated fat and cholesterol.
- Eat foods with adequate starch and fiber.
- Avoid too much sugar and salt.
- If you drink alcohol, do so in moderation.

Weight Control

If you can grab more than an inch of fat when you pinch your waist or arm, then you need to do something about your weight.



If you have a weight problem that is not due to a medical condition, think seriously about what prompts you to overeat, and try to avoid such situations.

For most people overeating is a fixed response to a situation: anger, stress, boredom, the stimulus of the sight or smell of food.

If you realize that your greatest weakness for food occurs when you are

angry, for instance, you can take the first important step towards changing that fixed response. Let the anger out in an active way, like exercise. Avoid the food.

To help avoid overeating, try some of these ideas:

- Reduce portions of food.
- Eat slowly and put your fork down between mouthfuls.
- Eat with a cocktail fork, so you'll take small bites.
- Drink as much cold water as you can before you eat to reduce food capacity.
- Eat in one room all the time, and make food off limits in other rooms.

About Smoking and Drinking

Finally, cut out—or at least cut down—on your smoking and drinking. All evidence strongly suggests these two items will do you in more quickly and thoroughly than most activities with the exception of hard drugs and poison.

If you have tried to quit smoking, failed repeatedly, and made up your mind you are going to smoke no matter what, try these tips to cut down on the danger of your habit:

- Choose a cigaret with less tar and nicotine.
- Don't smoke your cigaret all the way down.
- Take fewer draws on each cigaret.
- Smoke fewer cigarets each day.

In these ways, you can help give yourself a measure of protection against the hazards of the habit. But remember, this does not make smoking "safe." It's only a compromise.

To manage your drinking more effectively, the experts recommend drinking in moderation. Other suggestions include:

- Always sip slowly. Gulping alcohol will produce a massive rush of the drug into your blood and hence to your brain.
- Eat before you drink. This is an absolute rule of safe drinking because food in the stomach—preferably protein or fatty products—delays the rush of alcohol to your bloodstream.
- Alcohol is better not taken when you are physically or emotionally upset, or alone. It is no substitute for another person. Its anesthetic effect will dull the pain and loneliness only temporarily.

Common Sense Habits

A number of studies support the view that by practicing these common sense habits you can improve your health.

A University of Wisconsin study of more than 2,000 Americans who lived longer than average is a case in point.

Dr. J. Robert Samp, who conducted the research, said the results showed clearly that the following five-point program could add years to your life:

- Accommodate yourself to life's challenges.
- Avoid prolonged stress.
- Develop outside interests.
- Eat and drink sparingly, but with enjoyment.
- Continue to work later in life, either at paid or volunteer activities.

Other items that may be instrumental in prolonging life, he said, include:

- **Sleep.** "It is essential for survival, and the older you get the more you need."
 - **Contentment.** "Seek reasons to be happy instead of courting the eternal damnations that beset you."
 - **Moderation.** "Smoke within reason, keep drinking to social occasions and use it as a relaxant rather than a crutch."
- And above all, he admonishes, "Don't fight your enemies, outlive them."

That long life is no accident is also the conclusion of another study by the American Medical Association of Americans over 100 years old.

When asked what kept them young, the centenarians told the AMA: an easy going disposition, a quick sense of humor and a desire to keep alive and active.

Actually, it all comes down to this: Many of our serious health ailments can be avoided, or at least minimized and controlled, if the average person really wants to do something about it.

Truly, this concept of self-responsibility for one's health seems to be an idea whose time has finally come.

To put it personally: If you were told that there was a way to add productive years to your life while also sparing you the pain and suffering of preventable illness, would you be interested?

And, would you pursue it even though you knew to attain this goal required a change in your lifestyle, a new dedication and a genuine personal involvement?

The choice is yours . . .

Other **Consumer Notes** include:
A326 *Choosing Financial Advisers*
B326 *Changing Life Insurance Products*

All issues of **Consumer Notes** may be obtained free-of-charge in single or bulk quantities by writing to:

Community and Consumer Relations
American Council of Life Insurance
Health Insurance Association of America
1850 K Street, NW
Washington, DC 20006-2284

Family
 Budget
 Counseling

EXPENSE WORK SHEET

☐

MONTHLY

☐

BI-WEEKLY

☐

WEEKLY

FOOD

Supermarket _____
 Non-taxable Items _____
 Snacks, Candy, Beverages _____
 Coffee Breaks _____
 Lunches Out _____
 Other _____

HOUSEHOLD

Rent _____
 Mortgage _____
 Maintenance & Repairs _____
 Cleaning Supplies, etc. _____
 Other _____

UTILITIES

Electric _____
 Gas _____
 Phone _____
 Water & Sewer _____
 Other _____

TRANSPORTATION

R.T.A., Taxi _____
 Car Payment _____
 Gasoline _____
 Maintenance & Repairs _____
 Car Replacement Fund _____
 License Plates - Tags _____
 Other _____

CLOTHING

Head(s) of Household _____
 Children _____
 Other Dependents _____
 Dry Cleaning _____
 Other _____

HEALTH

Doctor _____
 Dentist _____
 Prescriptions _____
 Medical Insurance _____
 Other _____

EDUCATION

Tuition _____
 Books & Supplies _____
 Room & Board _____
 Other _____

TOTAL COLUMN I _____

INSURANCE

Life _____
 Homeowners' _____
 Auto _____

OUTSIDE SERVICES

Barber/Beautician _____
 Cleaning Help _____
 Gardener _____
 Snow Removal _____
 Other _____

SUBSCRIPTIONS

Newspapers _____
 Magazines & Books _____

ENTERTAINMENT

Dinner Out _____
 Movies, Theatre, etc. _____
 Alcoholic Beverages _____
 Hobbies _____
 Vacation Fund _____
 Other _____

DONATIONS

Church _____
 Other _____

OUTSTANDING OBLIGATIONS

Department Stores _____
 Master Charge/Visa, etc. _____
 Oil Companies _____
 Loan Repayment _____
 Past Due Utilities _____
 Other _____

TAXES

Federal _____
 State _____
 County _____
 City _____

MISCELLANEOUS

Dues & Membership _____
 Personal Sundries _____
 Gifts _____
 Baby Needs _____
 Pet Needs _____
 Other _____

TOTAL COLUMN II _____

TOTAL EXPENSE FOR PERIOD
 (COLUMN I + COLUMN II) _____

TOTAL INCOME FOR PERIOD _____

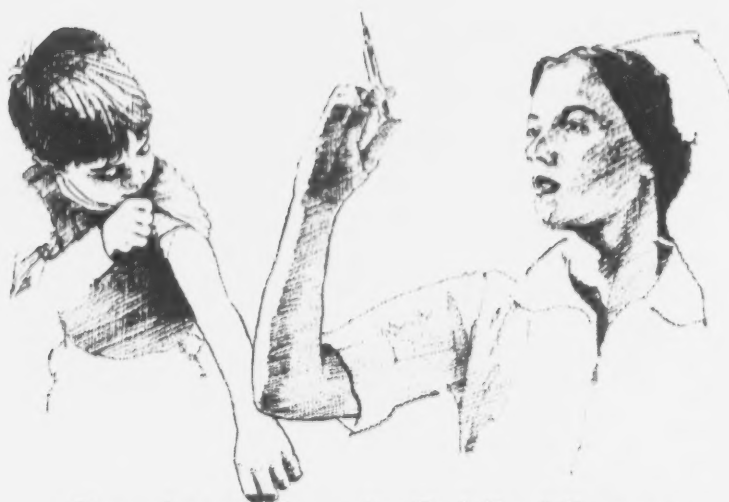
AMOUNT OVER/UNDER _____

DEVELOPED BY: E. A. Kaufman, Volunteer Counselor
 Family Budget Counseling Program

EUCLID COUNTY
 COOPERATIVE EXTENSION SERVICE
 2200 West 45 Street
 Cleveland, Ohio 44102
 (216) 631-1890



**Free and Low-Cost
Medical Resources
in
Cuyahoga County**



**Cuyahoga County Public Library
Information and Referral Service**



I. MENTAL HEALTH RESOURCES

IA. Mental Health Emergencies & County - Wide 24 hour Referral Programs.

1. Alcoholics Anonymous. 241-7387
940 Rockefeller Building
614 Superior Avenue, N. E.
Cleveland, Ohio 44113
Telephone is answered 24 hours a day. Will provide information on nearest meeting plus personal support.
2. Alcoholism Services of Cleveland
3030 Euclid Avenue, Suite 102, ... 391-2300
Cleveland, Ohio 44115

15401 Detroit, Room 104
Lakewood, Ohio 44107 226-2844
24 hour hotline for those with alcohol problems and their families. Referral to treatment.
3. County Mental Health Emergency Service/Psychiatric
Emergency Evaluation & Referral Service
10900 Carnegie Avenue, Room 400
Cleveland, Ohio 44106 229-2211
24 hour telephone emergency response to evaluate psychiatric & suicidal, crises, and to provide referral to an on-going treatment resource.
4. Gamblers Anonymous 771-2248
c/o YWCA
3201 Euclid Avenue
Cleveland, Ohio 44115
24 hour answering service will refer to nearest meeting and put the compulsive gambler in touch with help.
5. Narcotics Anonymous 1-800-451-3000
P. O. Box 02413
Cleveland, Ohio 44102
12 groups meet in the Greater Cleveland area. Hotline is answered 24 hours a day.
6. Parents Anonymous. 229-8800
11234 Bellflower Road
Cleveland, Ohio 44106
Maintains a drop-in center with day care facilities as well as support groups for parents having problems with physical abuse of children.
7. Women Together Shelter House 431-6267
3201 Euclid Avenue
Cleveland, Ohio 44115
Battered Woman 24 hour Hotline 961-4422
Temporary Shelter for women in crisis and abusive situations. Advocacy, counseling, referral to legal services.

IB. Community Mental Health Centers

The following agencies provide individual & family counseling & serve specific neighborhoods & communities.

1. CIT Mental Health Services 371-6200
2177 South Taylor Road
University Heights, Ohio 44118
Provides on a 24-hour basis, mental health information, evaluation, referral and follow-up services for short-term emergencies, as well as individual and family counseling. Primary service area is the eastern suburbs of Cuyahoga County.

2. **Center For Human Services** 241-6400
 1001 Huron Road
 Cleveland, Ohio 44115
 Homemaker services for the chronically ill. Individual, family, and group counseling. Day care and early childhood education programs. Therapeutic programs for children with developmental difficulties.

 East Counseling Unit 851-3208
 15040 Euclid Avenue
 Cleveland, Ohio 44112

 Southwest Counseling Unit 888-0300
 5955 Ridge Road
 Parma, Ohio 44129

 Community Mental Health Center for Southwest Suburbs.

 West Counseling Unit 252-5800
 3929 Rocky River Drive
 Cleveland, Ohio 44111

 Community Mental Health Center for Brook Park, Berea, Middleburg Heights, West Park area of Cleveland.
3. **Community Guidance Incorporated** 431-7774
 3134 Euclid Avenue
 Cleveland, Ohio 44115
 Serves East side, West-Central, and Goodrich-Downtown areas of Cleveland with mental health services and counseling.
4. **Far West Center** 779-5010
 26777 Lorain Road, Suite 614
 North Olmsted, Ohio 44070
 Individual and family counseling for suburban residents on the far west side.
5. **Marymount Mental Health Center.** 581-0500
 12300 McCracken Road
 Garfield Heights, Ohio 44125
 Full range of mental health services and counseling offered. For residents of the Southeast suburbs.
6. **Northeast Community Mental Health Center** 451-1141
 15735 Euclid Avenue
 Cleveland, Ohio 44112
 Serves East Cleveland, and the Glenville & Collinwood areas of Cleveland as well and Bratenhal - FULL service community mental health center.
7. **Westside Community Mental Health Center** 631-9100
 8301 Detroit Avenue
 Cleveland, Ohio
 Special program to treat alcoholism, the UnBar, as well as family and individual counseling. Serves the near-west side of Cleveland. UnBar is a county-wide program. Other services are restricted to the near-west side.
- IC. Counseling Services With A Religious Affiliation**
1. **Catholic Counseling Center** 696-6650
 1001 Huron Road
 Cleveland, Ohio 44115
 Psychiatric and counseling services for children, adolescents and families. Fees according to ability to pay.

2. Greater Cleveland Counseling Services 231-6004
c/o Inter-Church Council of Greater Cleveland
2230 Euclid Avenue
Cleveland, Ohio 44115
Individual, family and marital counseling by concerned clergymen. Respects confidentiality of caller.
3. Jewish Family Service Association 371-2600
2060 South Taylor Road
Cleveland Heights, Ohio 44118
Individual and family counseling. Fees based on ability to pay.
4. Salvation Army
P. O. Box 5847
Cleveland, Ohio 44101
Rehabilitation of employable people. Family and individual counseling.

II. MEDICAL & DENTAL SERVICES

1. Case Western Reserve Dental Clinic 368-3200
2123 Abington Road
Cleveland, Ohio 44106
Root canal work & a wide range of dental services done by students under the supervision of an instructor.
2. Cleveland Department of Public Health & Welfare Health Centers:
 1. J. Glen Smith 249-4100
11100 St. Clair Avenue
Cleveland, Ohio
 2. T. McCafferty 651-5005
4242 Lorain Avenue
Cleveland, Ohio
 3. Miles - Broadway 883-3260
9127 Miles Avenue
Cleveland, Ohio
 4. Tremont Health Center 241-6539
2358 Professor Street
Cleveland, Ohio

Full service health clinics are available to City of Cleveland residents.
3. Cleveland Metropolitan General Hospital 459-5325
Patient Information Service
3395 Scranton Road
Cleveland, Ohio 44109
Special services include dental care, oral surgery, comprehensive maternity & pediatrics care.
4. Cleveland Neighborhood Health Services/Hough-Norwood
Family Health Centers
8300 Hough Avenue 231-7700
1465 East 55th Street 881-2000
12100 Superior Avenue 851-2600
Provide complete pediatric & adult medical services as well as dental services, ob-gyn, optometry.

5. Cuyahoga Community College - Dental Hygiene Clinic
Metro Campus - Science and Technology Building Room 127
2900 Community College Avenue
Cleveland, Ohio 44115 348-4413 or 348-4411
Students examine and clean teeth. Check-up includes X-rays and fluoride treatment. Cost is \$1.00 for adults and 50¢ for children.

6. Cuyahoga County Board of Health 443-7500
112 Hamilton Avenue
Cleveland, Ohio 44114
Well baby clinics located throughout the suburbs. Call office for referral to nearest branch.

7. Free Medical Clinic 721-4010
12201 Euclid Avenue
Cleveland, Ohio 44106
..... Together Hotline: 721-1115
General medical care for adults and children. Hotline for late hours. Phone counseling for crisis situations.

8. Health Care For the Homeless
Offered at 2 sites

City Mission
408 St Clair Avenue
Hours: Monday, Wednesday, Thursday - 5:00 - 8:00 p. m.

Salvation Army Harbor Light Complex
East 18th & Prospect
Hours: Monday, Wednesday, Friday - 1:00 - 5:00 p. m.
No appointment is necessary. Health term provides general medical care, inoculations plus referral to Metro General or City Health Clinic for more serious problems.

9. Huron Road Hospital 761-4260
13951 Terrace Road
East Cleveland, Ohio 44112
Outpatient Department
General health care & check-ups offered. No maternity or dental care, however accept medicaid.

10. Kenneth W. Clement Center 391-3200
For Family Health
2500 East 79th Street
Cleveland, Ohio 44104
Full service health clinic includes ob-gyn, pre-natal pediatric, dental, and eye.

11. Mt. Sinai Medical Center 421-3629
1800 East 105th Street
Cleveland, Ohio 44106
Ambulatory Clinic
Clinic services include dentistry & oral surgery, eye, family planning, medicine, ob-gyn, pediatrics and psychiatry.

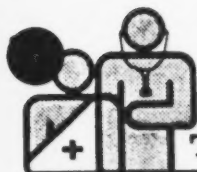
12. Project '83 368-1983
Academy of Medicine
11001 Cedar Avenue
Cleveland, Ohio 44106
Over 1400 Cuyahoga County physicians and 200 dentists have agreed to provide free care to workers laid off as of December 31st, 1980, who do not have medical benefits.

13. St. Luke's Hospital - Ambulatory Care Clinic 368-7810
11311 Shaker Boulevard
Cleveland, Ohio 44104
14. St. Vincent's Charity Hospital (Ext. 2090) 861-6200
Ambulatory Care Center
2351 East 22nd Street
Cleveland, Ohio 44115
Special services include strong pediatrics programs, dental care and Greater Cleveland Lions Eye Clinic which provides free or inexpensive eye exams & glasses.
15. Tel.-Med 231-6800
Academy of Medicine of Cleveland
11001 Cedar Avenue
Cleveland, Ohio 44106
Collection of tape recorded messages on a wide variety of health topics.
16. University Hospitals of Cleveland 884-3844
Clinic Information
2074 Abington Road
Cleveland, Ohio 44106
Free or inexpensive health care, based on the ability to pay is available to county residents. Phone for appointment. Special programs include family planning clinic, ob-gyn, pediatrics, & psychiatry.

BRANCHES OF
CUYAHOGA COUNTY PUBLIC LIBRARY

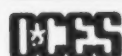
BAY	Bay Village	377 Dover Center Road	871-6392
BEA	Berea	7 Berea Commons	234-5475
BED	Bedford	155 Center Street	439-4997
BKL	Brooklyn	4480 Ridge Road	398-4600
BPK	Brook Park	6155 Engle Road	267-5250
BRV	Brecksville	8997 Highland Drive	526-1102
CHF	Chagrin Falls	100 East Orange Street	247-3556
FPR	Fairview Park Regional	4449 West 213th Street	333-4700
GAT	Gates Mills	Old Mill & Epping Roads	423-4808
GFH	Garfield Heights	5409 Turney Road	475-8178
IND	Independence	7121 Valley View Drive	447-0160
MDH	Middleburg Heights	15600 East Bagley Road	234-3600
MHR	Maple Heights Regional	5225 Library Lane	475-5000
MYR	Mayfield Regional	6080 Wilson Mills Road	473-0350
NOL	North Olmsted	27425 Butternut Ridge Road	777-6211
NRY	North Royalton	14600 State Road	237-3800
OLF	Olmsted Falls	7850 Main Street	235-1150
ORG	Orange	31300 Chagrin Boulevard	831-4282
PAH	Parma Heights	Greenbrier Commons, 6206 Pearl Road	884-2313
PAR	Parma Regional	5850 Ridge Road	885-5362
PAS	Parma-Snow	2121 Snow Road	661-4240
SEU	South Euclid - Lyndhurst	4645 Mayfield Road	382-4880
SLN	Solon	33800 Inwood Drive	248-8777
STV	Strongsville	13213 Pearl Road	238-5530
WVH	Warrensville	22035 Clarkwood Parkway	464-5280
HQS	Headquarters Administration Building	4510 Memphis Avenue	398-1800





Making Sense of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



SECTION II-A

HEALTH CARE COVERAGE NEEDS ASSESSMENT SURVEY

There is no simple formula for determining the exact amount of health care coverage an individual or family should have. However, by using the following checklist of major factors to consider in assessing your needs for health care coverage you can identify areas where you are meeting your needs and area where you may have gaps in coverage.

PAST HEALTH HISTORY

What is the health status of you and/or family members? Have there been relatively few illnesses? _____ YES _____ NO
Have there been many illnesses? _____ YES _____ NO

Does a family member have a chronic health problem which will require treatment? _____ YES _____ NO

What were your average yearly medical expenses for the past few years? \$ _____

STAGE IN FAMILY LIFE CYCLE

What is your stage in the family life cycle?

_____ Single Young Adulthood - you may be reaching the point when you are no longer eligible for coverage under the family's plan. There is a need to explore options before this occurs.

_____ Married. You may need to be sure your coverage includes pregnancy and child birth as well as well-child care.

_____ Pre-retirement -You need to periodically review coverage to be sure it is up-to-date.

_____ Working: Ages 65-69 - You must decide whether to remain on your employer's current health plan with Medicare supplementing or choose Medicare as the primary plan.

_____ Retired- Since Medicare only covers about 40% of medical costs, you need to decide whether to purchase supplementary coverage.

FUTURE HEALTH REQUIREMENTS

Are there unusual health hazards (risk factors) associated with your job? _____YES _____NO

Your community? _____YES _____NO

Your life style? _____YES _____NO

Is surgery a distinct possibility for a family member? _____YES _____NO

Does a family member have special needs such as allergies which may require testing and treatment? _____YES _____NO

Is a family member having drug, alcohol, or emotional problems which require the services of a special facility? _____YES _____NO

Does your family's genetic history place you at a greater risk of developing an expensive illness or condition which would require extended coverage under a major medical policy? _____YES _____NO

Is a family member reaching an age when there may be a need for coverage for extended care such as a nursing home? _____YES _____NO

HOW MUCH YOU CAN AFFORD

After reviewing your budget, how much money is available monthly for premiums? \$ _____

How much for medical costs not covered (such as deductibles)? \$ _____

Can you reduce your flexible expenses to free up money for medical costs or insurance? _____YES _____NO How much? \$ _____

Can you afford to self-insure for the smaller expenses associated with a higher deductible in order to save on premiums? _____YES _____NO

WHAT PROTECTION YOU ALREADY HAVE

Are you covered for basic medical expenses including the costs associated with hospitalization, surgery, and physician's services?

____ YES ____ NO

Are you covered for catastrophic health care expenses through a major medical policy?

____ YES ____ NO

Are you covered under a comprehensive health insurance policy that covers both basic medical and catastrophic expenses?

____ YES ____ NO

Are you covered under Medicare?

____ YES ____ NO

Do you have coverage to supplement Medicare through a Medigap policy?

____ YES ____ NO

Are you a member of a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) which provides comprehensive coverage?

____ YES ____ NO

Would you qualify for benefits under Worker's Compensation?

____ YES ____ NO

Would you be eligible for disability benefits under Social Security should you become disabled?

____ YES ____ NO

Do you have any provision for medical benefits under your liability insurance?

____ YES ____ NO

Do you have a provision for disability benefits under your life insurance?

____ YES ____ NO

After you have completed this survey, answer the following questions.

1. Do you feel that your coverage for health care costs is adequate for your needs? Are all family members adequately protected?
2. Are there any areas where your coverage should be improved?
3. What services do you need or feel you might want which are not included?
4. What changes are you planning to make?

LEADER TEACHING GUIDE

II. MATCHING HEALTH CARE NEEDS WITH OPTIONS FOR COVERAGE

B. TYPES OF HEALTH CARE COVERAGE

Lesson Outline

After needs are reviewed and available money is determined, the consumer must decide on the best plan. The following are types of health care coverage consumers may choose from:

- I. Basic Medical Expense Coverage - protection from three areas of medical costs.

A. Hospital Expense Coverage* - pays:

1. Room and board
2. Routine nursing care
3. Lab tests and x-rays
4. Use of operating room
5. Anesthesia
6. Drugs and medication
7. Ambulance service

B. Surgical Expense Coverage* - pays:

1. Surgeon's fees
 - a. Up to a set limit or
 - b. Full amount of U & C (usual & customary) charge
2. Assignment - surgeon accepts amount insurance pays

C. Medical Expense Coverage* - pays:

1. Doctor's services other than surgery
2. Up to a set limit or U & C charge
3. May include some payment for psychiatric treatment or skilled nursing facility.

II. Major Medical Coverage (Catastrophic)

A. Supplements basic coverage

B. Serious injury or prolonged illness

* Depending on the policy/plan, a deductible clause and co-insurance payment may apply.

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review fact sheet, "Types of Health Care Coverage." Using Exhibit II-B, list major types available to consumers using outline or chart provided. Discuss each type.

Secure samples of one or more types of insurance policies. Distribute appropriate Policy/Plan comparison worksheet, (i.e., 1. Hospital Insurance: Inpatient; 1. Hospital Insurance: Outpatient; 2. Medical/Surgical; 3. Major Medical).

Complete (as a group) worksheet appropriate to policy being analyzed.

III. Comprehensive Medical Insurance

- A. Combines basic and major medical
- B. Co-insurance and deductible clause
- C. Extensive maximum benefits

IV. Hospital Confinement Indemnity Insurance

- A. Pays Fixed Amount
 - 1. Daily, weekly, or monthly
 - 2. Supplements basic coverage
 - 3. Some have waiting periods

V. Limited Benefit Insurance

- A. Specific (Dread) Disease (Cancer, Heart Disease)
 - 1. Limited benefits
 - 2. Supplements basic coverage
- B. Skilled Nursing Home
 - 1. Pays daily rate
 - 2. Skilled care only (not custodial)
 - 3. Specific definition of "qualified" home in most policies
- C. Accident Only
- D. Intensive Care Insurance

VI. Disability Income Insurance

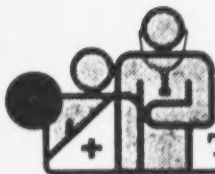
- A. Pays weekly or monthly
- B. Definitions of disability vary
- C. Replaces portion of income (60%) or provides set amount

VII. Medicare Supplement Insurance

- A. Pays deductible and co-insurance not paid by Medicare
- B. Pays at Medicare approved rates.

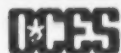
Secure cancer insurance policy. Review exclusions, limitations, etc., with participants. Debate value of this type of insurance. Discuss TV ads by national celebrities.

For more information, read "What Consumers Should Know About Health Care Services and Health Insurance" by the National Coalition for Consumer Education.



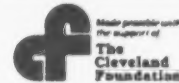
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SECTION 11-B

TYPES OF HEALTH CARE COVERAGE

After reviewing your needs and determining how much you can afford to spend, you must decide which policy or plan is best. Remember, you are purchasing health care coverage to protect yourself from the large out-of-pocket expenses associated with medical care. You will want to be sure you are covered first for the most common forms of medical expenses (hospital and doctor's fees) described below. Only after that should you consider special supplementary types of coverage.

Basic Medical Expense Coverage -- Covers three areas of medical costs. Frequently, they are lumped together in one type of basic plan or policy, such as in group or Blue Cross/Blue Shield programs. It includes:

Hospital Expense Coverage -- Included in coverage is room (semi-private) and board, routine nursing care, lab tests, x-rays, use of operating room, intensive care, anesthesia, drugs, medication and ambulance service. Some policies may not cover the actual charges for the room. The insured may be required to pay a specific amount (a deductible) before the insurance will pay any of the costs. The insured may also be required to pay a certain percentage of all costs (co-insurance), sometimes up to a specific amount. Outpatient hospital services may also be covered.

TIP: The average hospital stay, according to the American Hospital Association, is just under 8 days. Some policies do not provide coverage for the first 7 or 8 days of hospitalization.

Surgical Expense Coverage -- Covers surgeons' fees, either up to a limit spelled out in the contract, or the full amount of the surgeon's usual and customary (U & C) fee. Physicians may choose to accept the amount covered by insurance provided the insurance is paid to the physician instead of the insured. This is known as "accepting assignment." In such cases, the physician cannot bill the insured for any difference between the physician's usual fee and the amount paid by the insurance company. If the physician does not accept assignment, the insured still must pay the deductible and co-insurance portion of the bill, and will also be liable for any other amount not covered by insurance.

TIP: Some policies or plans cover minor surgery which is performed out of the hospital, in the doctor's office, for example. Others cover only operations performed in the hospital; so be sure to check this out, particularly with more and more procedures being performed on an outpatient basis.

Medical Coverage -- This provides for payments of physicians' services other than surgery. Some plans also cover some diagnostic and laboratory tests. Coverage for maternity care may or may not be a part of the coverage. Insurance may cover medical expenses in full or may specify a maximum amount that will be paid. Provisions for at least partial payment for psychiatric treatment is included in some plans, as is care in an extended care or skilled nursing facility.

NOTE: Under Blue Cross and Blue Shield arrangements, Blue Cross is the hospital expense insurance portion of the plan and Blue Shield is the medical-surgical expense portion which covers some physicians' fees which do not involve surgery. One of the unique characteristics about this insurer is that everyone in the same geographic location may join, either on a group or individual basis. There are numerous plans, and each one offers somewhat different benefits. Therefore, two families carrying Blue Cross-Blue Shield from different regions of Ohio can have different benefits.

Major Medical Coverage -- Major medical coverage (sometimes called catastrophic coverage) is designed to cover expenses that result from serious injury or prolonged illness. Major medical is frequently purchased to supplement basic health care plans. Coverage starts where the basic plan stops. In general, major medical covers all care and treatment prescribed by a physician. Major medical policies usually have a deductible clause and a co-insurance provision (for example, patient is responsible for first \$500 of costs for covered services and 20% of remainder).

Comprehensive Medical Insurance -- This plan is rapidly becoming the common form of health insurance offered through group plans. It is basically a combination of a basic and major medical plan.

It generally has a co-insurance provision and a deductible clause in which you pay a certain percentage of the bill, depending on the policy. Like major medical, the maximum benefits are usually extensive. This type of insurance is more expensive than either basic health insurance or major medical. However, it is usually less expensive than the same coverage purchased in two or more separate policies. It avoids duplication and gaps in coverage that may occur when several different policies rather than one comprehensive plan is purchased.

The following special types of insurance policies are designed to supplement the more necessary types of coverage described previously and are not designed to take the place of that protection.

Hospital Confinement Indemnity Insurance -- Hospital confinement indemnity insurance pays a fixed amount of money on a daily, weekly, or monthly basis when you must stay in a hospital. The benefits paid are not based on actual expenses. This type of policy should be used to supplement rather than substitute for basic medical expense insurance. Some of these policies have waiting periods and exclusions pertaining to certain illnesses so that benefits will not be paid until the patient has been in the hospital for a certain number of days.

Limited Benefit Insurance -- These policies cover only stated expenses arising out of specifically named illnesses, or circumstances. Generally, the premiums are low, and the benefits are often limited. According to experts, these policies should only be used to supplement rather than substitute for basic medical expense insurance policies. Four examples are:

Cancer and Other Specified (Dread) Disease Insurance Policies only pay benefits for certain diseases, usually cancer or heart disease. Some of these policies pay benefits based upon actual medical expenses for treatment of the disease. Others pay a certain amount of money (an indemnity) for hospital confinement and outpatient treatment for the disease, or pay a one-time fixed lump sum indemnity benefit payment. Some policies provide a combination of benefits. Cancer policies pay benefits for the actual treatment of cancer, and some policies may pay benefits for any other conditions or diseases caused or aggravated by cancer or the treatment of cancer.

Skilled Nursing Home Insurance -- These policies provide a specified benefit for each day of confinement in a qualified skilled nursing home and only if the patient is receiving skilled nursing care. Custodial care (help in walking, bathing, dressing, eating) is rarely covered. Some insurance companies are beginning to market nursing home insurance which may pay for custodial care, usually after certain conditions (such as hospitalization) are met for a limited amount of time.

For benefits to be paid, most skilled nursing home policies require that:

- * The patient be confined to a hospital for at least three days before entering a nursing home;
- * The patient be admitted to a nursing home within 14 days after release from a hospital;
- * The patient's nursing home admission must be for the same condition that required hospital confinement;
- * The patient's doctor states that confinement is medically necessary for a sickness or injury and that there is a positive prognosis of getting better.

Accident Only Insurance -- Cover death, loss of limb or sight, disability, or hospital and medical care due to an accident, not an illness.

Intensive Care Insurance -- Provide coverage only while you are in an intensive care unit (ICU) of a hospital.

Disability Income Insurance pays a weekly or monthly income benefit if a person is disabled due to a covered injury or sickness. This type of insurance can provide an income to partially replace wages lost when a person is unable to work for an extended time. Disability income policies have elimination periods before benefits become payable. The longer the elimination period, the lower the premium will be. The definitions of total disability vary from policy to policy, so be very careful to read the fine print.

The amount of monthly benefit provided by a disability income policy may be stated as a percentage of income or as a set dollar amount. The amount of benefit for which you can qualify is usually based on a percentage of your gross earnings, normally around 60%. Some policies may reduce your benefit any amount that you receive from Social Security so that your disability benefit and Social Security benefit together will provide a specified income.

Medicare Supplement Insurance -- Medicare does not cover all the health care costs of people who are insured by it. Numerous policies are available that supplement it. They are designed to pay for the deductible and some expenses not provided for by Medicare.

(To simplify information in this publication, trade names of some products and/or services are used. No endorsement is intended, nor is criticism implied of similar products not named.)

EXHIBIT II-B

TYPES OF HEALTH CARE COVERAGE

• BASIC MEDICAL EXPENSE COVERAGE

~ Hospital Expense

~ Surgical Expense

~ Medical Expense

• MAJOR MEDICAL COVERAGE

• COMPREHENSIVE MEDICAL INSURANCE

• HOSPITAL INDEMNITY INSURANCE

• LIMITED BENEFIT INSURANCE

~ Specific (Dread) Disease

~ Skilled Nursing Home

~ Accident

~ Intensive Care

• DISABILITY INCOME INSURANCE

• MEDICARE SUPPLEMENT INSURANCE

HOSPITAL INSURANCE: INPATIENT SERVICES

14 E. Minor Street's Entrance PA 19040

HOSPITAL INSURANCE: OUTPATIENT SERVICES

The following OUTPATIENT services should be covered by any policy you consider.

Self

ipouse

Dependence

Self

Figure 1

Dermatitis

11-11

Source

Design

Self

1

1

Accidental injury

Detoxification services (alcohol and drugs)

Diagnostic tests and procedures
(example, laboratory services, blood tests, x-ray, ultrasound)

Electrocardiogram (EKG)

Electroencephalogram (EEG)

Drugs and medications

Emergency room (as deemed necessary by company)

Home health care

Mental health and nervous disorders

Newborn care

Physical therapy

Pre-admission testing

Radiation therapy

Respiratory therapy

Surgery, short procedure
(example, anesthesia, recovery room, supplies)

Skilled nursing home care

Speech therapy

Transportation (ambulance)

List additional services covered.

EXCLUSIONS: List services *not* covered.

POLICY/PLAN COMPARISON WORKSHEET

MEDICAL-SURGICAL INSURANCE

[illegible]

POLICY/PLAN COMPARISON WORKSHEET

MAJOR MEDICAL INSURANCE

[illegible]

What Consumers Should Know About Health Care Services and Health Insurance

Americans are becoming smarter health care consumers. We are increasingly aware of our responsibility in staying healthy—even if we smoke we know the risks involved. We are also showing our concern about controlling the high cost of medical bills by becoming more informed about the use of health care services. In addition, as the cost of a major illness steadily climbs, Americans are aware of the need for adequate health insurance.

The National Coalition for Consumer Education has developed this publication to provide information to consumers about health care. It covers two basic areas: (1) health care services and (2) health insurance. We hope you find it useful.

Health Care Services

Until recently, our choices within the health care system were limited. If ill, we visited a physician who was probably not a specialist, and if our illness warranted it, we were admitted to a hospital. Today, however, we are faced with a variety of alternatives within a health care system that is changing rapidly. Some of the changes are fueled by advances in medical technology. Some of the changes have developed in response to the rising cost of health care, especially the most expensive form of care, inpatient hospitalization. And some of the changes are a result of a new emphasis on preventive medicine rather than treatment.

What follows is basic information about health care services.

1. What is the difference between the service provided through a health maintenance organization (HMO) and by a private doctor?

Health maintenance organizations provide a wide range of medical services for a fixed fee, usually monthly, that is paid in advance. HMOs place an emphasis on preventive medicine. Usually, all neces-

sary office visits, periodic physical examinations, immunizations, pap smears, vision and hearing examinations and other preventive services are covered under the fixed fee. HMOs may be especially attractive to families with young children who are frequently in need of routine care. If you do choose to join an HMO, you must use the doctors provided through the HMO facility.

If you are not a member of an HMO, you use the services of a doctor of your choice whose charges you pay on a fee-for-service basis.

2a. Must I always be admitted to a hospital for surgery?

The decision to operate no longer automatically means a hospital stay. More and more routine surgery is performed in the doctor's office, an outpatient unit at the hospital, a walk-in surgical center or a medical clinic.

Outpatient surgery may be appropriate for a number of operations, such as simple hernia repairs, removal of non-cancerous cysts, some types of cosmetic surgery and even cataract removal. If you need routine surgery, ask your doctor whether outpatient surgery is suitable.

2b. Must I always be admitted to a hospital for childbirth?

Along with the growth in walk-in surgical centers has been a growing interest in "birthing centers." Sometimes affiliated with a hospital and staffed with nurse mid-wives who often work under a doctor's supervision, delivery in a birthing center is less expensive than an in-hospital delivery and might be something you want to explore with your doctor/obstetrician.

3. When should I consider a second opinion?

If your doctor or specialist recommends surgery, it makes sense to confirm your doctor's advice with a second surgeon's opinion before undergoing any type of non-emergency surgery. This can greatly reduce the risk of unnecessary surgery. The practice is so well accepted that most insurance companies and Medicare now include the cost of a second opinion

for non-emergency surgery in their coverage. In fact, there is a growing trend in health insurance plans to reimburse the patient the full charge for non-emergency surgery only if a second opinion has been obtained. If not, the patient may only be reimbursed a percentage of the charge.

4a. What are my rights in the doctor's office?

As a patient, you are entitled to ask questions and make sure you understand your doctor's instructions. Communication is essential. Your doctor should make clear why you need surgery or medication as treatment for an illness, and the risks or side effects that may result from the treatment.

You should ask about options for treatment of a particular illness and be honest in expressing your concerns. If you are not satisfied with your relationship with your doctor, choose another.

4b. What are my rights in the hospital?

You also have rights as a hospital patient. For example, you are entitled to:

- Refuse to see anybody you do not wish to see.
- Request that a person of your own sex be present during an examination.
- Be transferred to another room if the behavior of someone else in the room disturbs you.
- Stipulate that your medical records be read only by those directly involved with your treatment.

You also have a right to check your hospital bill whether it is being paid by you or by your insurance company. You should check all subtotals such as room-and-care fees and services, operating room fees, lab fees, drugs, diagnostic tests and the like. If you find any discrepancies, discuss them with your hospital.

5. What are some alternatives to hospitalization?

A. Nursing Homes. After an initial stay in a hospital, some patients who are not well enough to return home may be able to move to a nursing home. Treatment can be continued in what is usually a more personalized environment. However, it is important to know whether your health insurance covers nursing home care. Virtually all health insurance policies exclude coverage for custodial care, which is non-medical care such as housekeeping and meal preparation.

B. Hospices. For some patients whose illnesses are terminal, a hospice provides an alternative to hospitalization. A hospice setting is more home-like and part of the hospice service is to provide emotional support to patients and their families. Again, find out whether your health insurance covers treatment in a hospice.

C. Home Care. Sometimes treatment at home is possible. Home care is simply more comfortable and less costly. In fact, in many cases the average person, when ill, not only prefers being home but will benefit from familiar surroundings.

The important things to know about home care are: (1) Is it medically advisable? and (2) Is it suitable for you? You must consider whether your home is quiet enough. Is a private room available? Is there room to maneuver a wheelchair or walker if needed? Are bathroom, kitchen and sleeping facilities accessible to each other?

Find out if there are services in your community, such as licensed practical nurses, that will provide home health care. Check with your doctor and your local hospital; some hospitals operate their own home care programs. You should also find out whether your health insurance covers home care services and if so, whether there are any conditions and limitations.

Health Insurance

A trip to the doctor for a routine physical examination is likely to be paid for out of the family budget. However, when confronted by a major illness or disability, health insurance protection is essential.

There are many ways to obtain health insurance. Most people are covered by a group plan provided by their employer or fraternal organization and issued from a commercial insurance company or Blue Cross/Blue Shield.

Health insurers offer a variety of policies with different levels of protection. For example, one policy may pay for the bulk of a family's medical bills while another may pay a preset amount toward hospitalization only. Generally, the more comprehensive the coverage, the more expensive the insurance.

1. What kinds of health insurance plans are available?

A. Basic Insurance Protection. Basic protection pays part of the hospitalization cost for room and board, nursing services, X-rays, lab tests and medication. In addition, part of the cost of surgical procedures performed in or out of the hospital, and visits to the doctor are paid. The benefits may also include such services as diagnostic tests and some laboratory tests.

Coverage may be limited as follows:

- If your policy has inside limits, usually expressed in dollar amounts for surgery and hospitalization, you will have to pay the remainder yourself.
- If your insurance entitles you to service benefits, a plan designed to pay bills in full, payment is made only on reasonable charges.
- You may not be covered for a lengthy hospital stay.

B. Major Medical Insurance. If you are hospitalized for a long time, run up catastrophically high bills, or have expenses such as private nurses, long-term prescription drugs, or ambulance charges, you need major medical protection.

Major medical policies provide more complete insurance than basic ones. However, like auto insurance, they have a deductible provision, that is the amount you must pay personally before your benefits begin. The deductible on individual or family policies may range from \$500 to \$5,000; the rule is the higher the deductible, the lower the cost of your insurance. Group insurance deductibles are usually much lower.

Major medical policies also have a co-insurance clause. Co-insurance is the part of your medical costs you are obligated to pay in addition to your costs under the deductible provision.

For example, major medical plans typically pay 80 percent of all eligible costs above the deductible; you pay the remainder to the maximum amount payable under the policy. In other words, with a medical care bill totaling \$10,000 of eligible expenses, you still pay about \$2,000 beyond the deductible amount.

Fortunately, many policies where you pay a share of the cost include a stop-loss provision that limits the amount you have to pay. These will specify that after you've personally paid, say, \$5,000, then the insurer will pay 100 percent of remaining covered medical expenses.

C. Hospital Indemnity Insurance. Hospital indemnity policies are limited in their coverage. They supplement basic or major medical protection. Their benefits are paid to you in cash during the time you are hospitalized.

As in the case of most individual major medical policies, hospital indemnity policies contain a waiting period on preexisting medical conditions if you are presently ill, or have been recently ill. Keep in mind that insurance payments for hospitalization under these policies don't all begin on the first day. Some start on the third, some on the eighth day. If you are not aware of this provision, you could be in for an unpleasant surprise.

2. I have health insurance through a plan where I work. How do I know if it is adequate?

Group insurance is the kind of health insurance you most often get through your job. Your employer usually pays some or all of the premiums. The protection provided by group insurance varies with each plan. You should check with your personnel or union office to find out what benefits are provided.

Your group coverage may not be adequate:

• if it fails to provide benefits for the major portion of your medical bills, hospital, doctor, and surgical

charges. The benefits should be high enough to meet the charges in your community.

- if your maximum health insurance benefit is only \$50,000. Because of the high cost of a major illness, it is advisable to supplement your coverage to at least \$250,000.

3. Do I need disability income insurance?

Disability income insurance provides regular cash income in case of disability through illness or injury. Until you are able to return to work, you continue to collect a percentage of your former earnings. If you are covered under a group health insurance plan, it does not mean that you are automatically provided with disability insurance. However, your employer may provide employees with this coverage.

In addition, it is likely a union contract will include sick-leave benefits. There are also state worker's compensation payments made for job-related disabilities. In some cases, Social Security also covers disabilities. If you are a worker who has been totally disabled by an illness or injury that will keep you out of work for at least one year, or that could cause your death, you are eligible for Social Security benefits after five months of being disabled. Before you consider purchasing an individual disability plan, know the protection to which you are already entitled.

If you purchase disability insurance, you should know:

- that most require that you be totally disabled before benefits begin.
- that there are different definitions of disability. For example, some policies define it as simply being unable to do your regular work, while others are stricter. In these, a dentist who could not continue regular work because of a hand injury would not be considered permanently disabled if the dentist could earn income through related duties, such as teaching dentistry.
- that policies pay benefits starting from a week to six months after the onset of the disability and may last as few as 13 weeks to as long as your lifetime. The greater the benefits, the greater the cost.
- that you cannot expect to insure yourself for your full salary. The most an insurer will allow is two-thirds of your gross salary. Therefore, if you are earning \$750 per week, you will be eligible for insurance of about \$500 a week.
- that house confinement is not a valid element of the medical definition of disability. Disability policies with this requirement should not be purchased.

If you purchase disability insurance, you should ask:

- for noncancellable and guaranteed renewable coverage or guaranteed renewable coverage to protect yourself from the policy being cancelled if you become a bad health risk.
- whether you are covered for both accidents and illness.
- for how long a time period the coverage extends.

A Consumer Checklist for Health Insurance and Disability Insurance

- If you pay your premiums directly, try to arrange to pay annually or quarterly rather than monthly. It is usually cheaper.
- Policies should be delivered to you within 30 days. If not, contact your insurer in writing to find out why. If 60 days go by, contact the state department of insurance.
- When you receive a policy, take advantage of the "free look" provision. You have 10 days to look the policy over and if you decide it is not for you, obtain a refund.
- Read your contract over every year to see if its benefits are still in line with medical costs.
- Don't replace your policy because you think it is out-of-date. Switching may subject you to new waiting periods and new exclusions. Add to what you have if necessary.
- Don't look to make a profit on your insurance by carrying overlapping coverages. Duplicate coverage is expensive. Besides, most group policies now contain a "coordination of benefits" clause limiting benefits to 100 percent of your covered charges.
- Maintain a health emergency fund to cover small expenses.
- If you're considering the purchase of a "dread disease" policy such as cancer insurance, be aware of its restrictions and limitations. It does not replace a comprehensive major medical insurance policy.
- Don't lie on your insurance application. If you fail to mention a preexisting condition, you may not get paid when you need it. You can usually get paid for that condition after one or two years have elapsed and there has been no treatment in that period for that condition.
- Health insurance applications for individual policies, for your protection as well as the insuring organization, should never be signed until full and complete answers are recorded for every question and until you have read and understand the policy and its benefits.

Resources

If you have questions that have not been answered in this brochure, you can get more information from a variety of sources. Some of them are listed below.

- your employer, union or association officer
- your insurance agent or your insurance company
- your health maintenance organization
- your state insurance department
- AARP, Health Advocacy Services, 1909 K Street, NW, Washington, DC 20049 (202/872-4700)
- Blue Cross/Blue Shield Association, 1125 15th Street, NW, Washington, DC 20005 (202/479-8000)
- Health Care Financing Administration, U.S. Department of Health and Human Services, Baltimore, MD 21207 (Medicare and Medicaid information, 301/597-3789.)
- Health Insurance Association of America, 1850 K Street, NW, Washington, DC 20006-2284 (For questions about individual health and disability insurance, 800/423-8000.)
- National Center for Health Education, 30 East 29th Street, New York, NY 10016 (212/689-1886)
- National Consumers League, Suite 202, West Wing, 600 Maryland Avenue, SW, Washington, DC 20024 (202/554-1600)
- Office of Health Maintenance Organizations, U.S. Department of Health and Human Services, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857 (301/443-1993)

This project was sponsored by the Health Insurance Association of America and the American Council of Life Insurance. For additional free copies, please write to:

Community & Consumer Relations
Health Insurance Association of America
1850 K Street, NW
Washington, DC 20006-2284

II. MATCHING HEALTH NEEDS WITH OPTIONS FOR COVERAGE

C. SOURCES OF HEALTH CARE COVERAGE

Lesson Outline

There are private and public sources of health care protection plans and insurance. Private sources include:

I. Prepaid Fee-for-Service Insurance plans

A. Available from:

1. Blue Cross/Blue Shield Associations
2. For-profit insurance companies (approximately 1,000 nationwide)
3. Independent groups offering health plans

B. Types of policies

1. Group

- a. Master policy or contract between insurance company group (i.e., employer)
- b. Members issued certificates
- c. Advantages:
 - (1) Lower premiums
 - (2) Coverage more comprehensive
 - (3) Pre-existing exclusions and waiting periods less frequent
 - (4) Rarely need to take a physical

2. Individual

- a. Can also cover dependents
- b. May supplement group coverage
- c. Usually more expensive
- d. Coverage, value, claims practices and costs vary widely

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review fact sheet "Sources of Health Care Coverage." Display "Options In Health Care Coverage - Persons Under Age 65," and discuss Exhibit II-C. Ask participants for examples under each type. How many participants have each type of coverage?

Ask participants to list the advantages of group insurance.

Distribute pamphlet "Health Care Coverage...When You Are Not In A Group." Copies available from Cuyahoga County Cooperative Extension Service, 3200 West 65 Street, Cleveland, OH 44102. Allow time for class discussion of options listed.

C. Ways to Purchase Coverage

1. Blue Cross/Blue Shield Representative
2. Insurance agent representing one company
3. Independent, multi-line, multi-company general agency or broker
4. Groups and organizations (i.e., labor unions, professional organizations, fraternal societies, trade associations).
5. Mail order.

II. Alternative Delivery Systems provide comprehensive hospital, surgical, and medical services at prepaid or pre-determined rates

A. Health Maintenance Organizations (HMOs) - provide a comprehensive package of services on a fixed, prepaid basis within a particular geographic area.

1. Group model has its own facilities and doctors on staff (i.e., Kaiser Permanente)
2. IPAs (Individual Practice Associations) offer prepaid services through doctors who practice out of their own offices (i.e., Health America; Western Reserve Health Plan; Health Care Network; HMO Health Ohio).

B. Preferred Provider Organizations (PPOs) - Groups of physicians and hospitals that contract on a fee-for-service basis to provide lower cost medical services to health plan subscribers, i.e., Emerald Health Network; Ohio Health Choice Plan; Preferred Care of Ohio.

Public sources include:

I. Medicare (Covered in Section V)

II. Medicaid

III. Workers' Compensation

IV. Social Security

Ask participants to cite examples of these groups.

Ask participants to describe TV commercials for mail-order insurance and/or bring samples of advertising literature to class. Debate pros and cons of this type of insurance.

Review fact sheet, "Health Maintenance Organizations." Using Exhibit II-D, "Health Maintenance Organizations," discuss how HMOs operate.

Using Exhibit II-E, "HMOs Two Models," discuss and compare two different models. Ask class to cite examples of each in local area.

Using Exhibit II-F, "Advantages of HMO Membership," and Exhibit II-G, "Disadvantages of HMO Membership," discuss each. Allow enough time for input from participants.

Using Chart, "How Much Will It Cost?," compare a fictional plan with an HMO as a sample on how to compare costs.

Review fact sheet, "Preferred Provider Organizations." Using Exhibit II-H, "Preferred Provider Organizations," discuss structure and functions of PPO's.

Using Exhibit II-I, "When Choosing an HMO or a PPO Consider These Steps," review with class key points to consider when deciding whether or not to join an alternative system.



Making Sense of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



SECTION II-C

SOURCES OF HEALTH CARE COVERAGE

Health care coverage is available from both private and public sources.

PRIVATE SOURCES:

Private Prepaid Fee-for-Service Insurance (Group or Individual) Plans are available from Blue Cross and/or Blue Shield organizations or from over 1,000 private, for-profit insurance companies. Some independent groups also offer health plans.

Group Insurance - in a true group insurance program there is a master policy or contract between the insurance company and a legal entity, such as an employer. Members are issued certificates that outline their benefits and identify family members or dependents who are covered.

Franchise Group Insurance - This is actually individual policies purchased through a group or association, and may include coverage for a spouse and dependents. With a franchise policy, the group or association agrees to collect the premiums for the insurance company. The franchise policy may have rates that are lower and benefits that are better than those found in a similar individual policy.

TIP: If you are asked to complete your own application as part of a group, it is most likely that you are purchasing "franchise insurance." The health history part of the application is very significant. If you omit what the insurance company considers "pertinent health," the company may plead fraud and deceit when you file claims.

This insurance is available through numerous groups:

Employers, Labor Unions, Professional Organizations, Fraternal Societies, Trade Associations, Civic Groups, Religious Organizations, Clubs, College Health Departments, College Alumni Associations, Rural and Consumer Health Cooperatives, Financial or Consumer Organizations

But you should shop around to be sure. If you are a member, it may be cheaper to purchase insurance through one of these groups.

Individual policies - can be bought to supplement a group policy which does not provide adequate coverage or to provide protection for persons who are not covered under group health insurance plans.

The coverage, value, and claims practices of companies selling individual policies vary widely. You should shop around to find the policy that is best suited to your needs.

Individual policies can be purchased through:

1. Blue Cross/Blue Shield Corporations - Plans vary from state to state and within states, so check the one you are considering carefully.
2. A one-company insurance representative (agent).
3. An independent, multi-line, multi-company general agency or broker.
4. Insurance companies, directly through the mails, usually, for a relatively low monthly price, these plans claim to offer supplementary insurance to fill gaps in your coverage. Most are "cash benefit" (indemnity-type) plans usually paid when you are in the hospital.

Since most mail-order policies have limited benefits because of exclusions, waiting periods or other clauses, the consumer must be very careful when considering one of these plans. Read the fine print and be sure you understand what you are buying or you might find out later that the insurance does not pay for some things you thought it did.

Alternative delivery systems offer comprehensive medical care at predetermined or prepaid rates. This includes hospital, surgical, and medical services. Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs) are examples of alternative delivery systems.

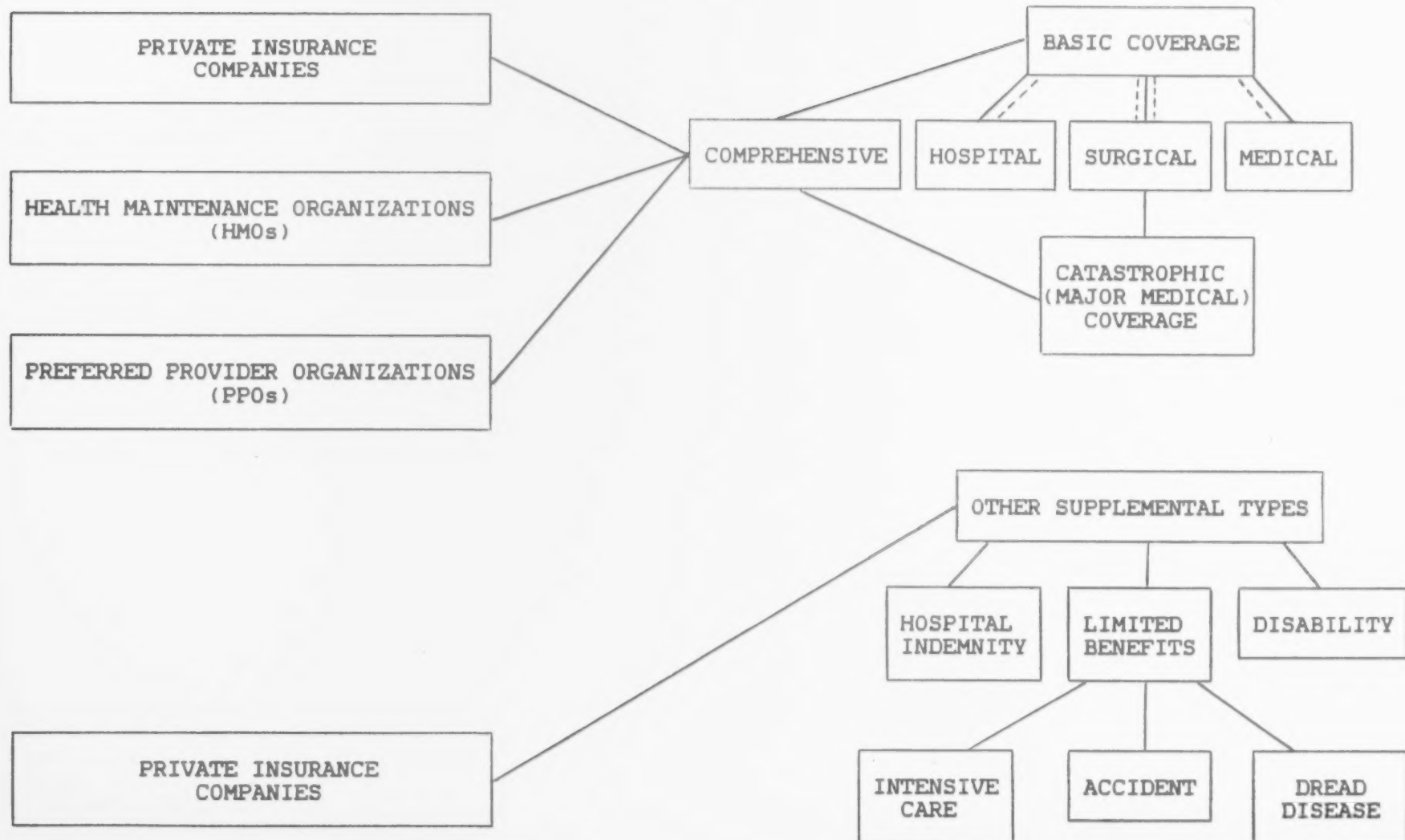
PUBLIC SOURCES: Public Plans for those who qualify cover basic medical costs. The two major public plans in the U. S. are Medicare and Medicaid. In addition, Workers' Compensation pays medical bills and weekly benefit to replace some wages for workers hurt on the job or in a job-related activity and Social Security disability benefits which pay benefits for long term or permanent total disability.

EXHIBIT II-C OPTIONS IN HEALTH CARE COVERAGE
PERSONS UNDER 65

CUYAHOGA COUNTY
COOPERATIVE EXTENSION SERVICE
3300 West 85 Street
Cleveland, Ohio 44102
(216) 831-1880
(216) 831-3450

SOURCES

TYPES



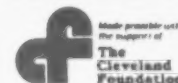


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SECTION II-C

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Health Maintenance Organizations, or HMOs, are one alternative form of health care coverage available today. An HMO provides comprehensive health care for members and their families on a prepaid basis rather than requiring payment after medical care is received. Thus, an HMO provides both health insurance and services through a single organization.

An HMO either directly provides or arranges for all the health services needed by its members. Sometimes an HMO has its own facilities where doctors are employed as a staff to see members. Another type, called an IPA, contracts with doctors in the community who treat HMO members out of their own offices. In addition to providing the health services usually covered by traditional insurance, HMOs provide routine office care and preventive health services with no deductibles or co-insurance. Some charge small co-payments for certain services.

Most people join an HMO through an employer. Employers with 25 or more employees who offer health insurance as a benefit are required to offer the choice of joining a federally qualified HMO, if there is one in the area. Some HMOs also accept individuals or families directly, either after a medical screening or during their once-a-year open enrollment period with no medical screening. For a complete list of HMOs in Ohio, write to: Information Department, Group Health Association of America, 624 Ninth Street, N.W., Washington, D. C. 20001.

The following HMOs are operating in the Greater Cleveland area (no endorsement intended):

KAISER-PERMANENTE HMO
Administrative Offices
1100 Bond Court Building
Cleveland, OH 44114
216/621-5600

HMO HEALTH OHIO
Administrative Offices
2066 East Ninth Street
Cleveland, OH 44115
216/642-3130

HEALTH AMERICA
2800 Euclid Avenue
Cleveland, OH 44115
216/579-9100
800/362-5506

WESTERN RESERVE HEALTH PLAN
19101 Villaview Road, Suite 207
Cleveland, OH 44119
216/486-0152

HEALTH CARE NETWORK
23200 Chagrin Boulevard
Beachwood, OH 44122
216/464-8446

New federal rules make it possible for Medicare recipients to enroll in HMOs, some of whom accept a limited number of elderly. Medicare HMO members pay a monthly premium in addition to their Medicare premiums for which they receive complete health care, thus eliminating out-of-pocket deductibles and limiting co-insurance to set amounts. HMO membership eliminates filing of most claims. Depending on an individual's HMO benefits, it can also do away with or limit the need for private medigap insurance.

Some features of HMO plans that are considered desirable by many persons include: One premium with few out-of-pocket costs; elimination of claim forms; and improved coordination of services. However, HMOs also have limitations that are considered undesirable by many consumers, including a more limited choice of doctors, hospitals, and other providers and the fact that coverage when traveling may be limited to HMO-defined emergencies.

If you are considering joining an HMO, you should investigate the HMOs you are thinking of joining and consider how they compare with your traditional health insurance and each other. Try to get recommendations from friends or co-workers who have used the services of an HMO. Visit the facility and talk to staff as well.

Here are some things to consider in your evaluation of an HMO:

1) BENEFITS - Compare services available from the HMO with services covered by your insurance plan. (Use Comparison of Benefits Worksheet.)

2) LOCATION - Is the HMO as easy for you to get to as the doctors you are now using? Remember, if you join an HMO, you must use its facilities or physicians' offices except in an emergency. Is public transportation available if you need it?

3) ACCESS - When you join an HMO, you will be able to select a primary care physician from its roster. Often, in an HMO, you will be able to receive care for the entire family at one central location. However, if you have a long-standing relationship with a personal physician, you should consider very carefully whether you are willing to switch.

4) **QUALITY** - Check to see if the physicians are board certified or eligible. This means they have met rigorous professional standards. Ask if the HMO has a quality assurance program which assures members of high quality care.

5) **COSTS** - Compare the total amount of out-of-pocket costs you might pay under each plan. This involves more than just the premium since many insurance plans require deductibles and co-insurance payments. The following chart will help you make this comparison.

<u>HOW MUCH WILL IT COST?</u>		
	<u>Current Plan</u>	<u>HMO</u>
Premiums	Enter Yearly premium you will pay ("0" if employer pays entire premium.	Enter yearly premium of HMO you will pay ("0" if employer pays entire premium).
	Yearly Premium Cost \$ _____	Yearly Premium Cost \$ _____
Unreimbursed Out-of-Pocket Costs	Enter all medical expenses you have paid in past year. (Use a 3-year average if possible. Include deductible and co-insurance payments, routine physicals, etc.)	Enter any expenses you of "deductibles," "co-payments" or "uncovered expenses." (With an HMO, this should be small figure or "0").
	"Out-of-Pocket" Costs \$ _____	"Out-of-Pocket" Costs \$ _____
Total Health Care Cost	Add yearly premiums to out-of-pocket costs.	Add yearly premiums to out-of-pocket costs.
	Total \$ _____	Total \$ _____

Source: Guide To Health Maintenance Organizations in Wisconsin, Cooperative Extension Service and School of Family Resources and Consumer Sciences, University of Wisconsin-Madison, 1984. Reprinted with permission.

QUESTIONS TO ASK BEFORE JOINING A

Health Maintenance Organization

Health maintenance organizations (HMO's) are an alternative to traditional health insurance. An HMO is a program providing comprehensive health care for members and their families at a fixed prepaid premium. Some features of HMO plans that are considered desirable by some persons are:

- one premium with few out-of-pocket costs
- eliminate filing of claims
- improved coordination of services

However, HMO's also have limitations that are considered undesirable by some consumers, including the following:

- limits choice of doctors, hospitals, and other providers
- coverage when traveling may be limited to HMO-defined emergency

Before you enroll in an HMO plan, you may wish to ask the following questions: (A separate form should be used for each plan considered.)

1. What are the premium costs of the plan? \$ _____ (annually) or
\$ _____ (monthly)
2. What is the waiting period for pre-existing conditions? _____
3. Are physicians with the following specialties affiliated with the HMO?
Which specialties are you likely to need?

Family physicians	_____	Anesthesiology	_____
Surgery	_____	Skin care	_____
Orthopedics	_____	Oncology	_____
Mental health	_____	Radiology	_____
Rehabilitation medicine	_____	Neurology	_____
Eye care	_____	Urology	_____
Pediatrics	_____	Other	_____
Obstetrics/Gynecology	_____		

4. What is the total number of doctors associated with the HMO? _____

Which doctors are board certified or board eligible?

5. Where do I obtain the following services and what coverage is included under this plan?

LOCATION

Hospital	_____
Primary care doctor(s)	_____
Specialists	_____
Prescription drugs	_____
Vision care	_____
Skilled nursing facilities/care	_____
Emergency center	_____
Mental health care	_____
Drug/alcohol abuse	_____
Dental care	_____
Family planning	_____
Other	_____

6. Which types of preventive care are covered by the plan?

Approved Health Education _____;
Routine Physical Exam _____;
Other _____.

7. Are extended plans available for additional costs?

Dental	_____	Mental Health	_____
Vision	_____	Hearing	_____
Pharmacy	_____	Alcohol/Drug Abuse	_____
Blood	_____	Custodial Care	_____

8. Does the plan pay for house calls? ____Yes ____No
Other home health care? ____Yes ____No

9. Does the plan pay for second opinions for recommended treatment? ____Yes ____No

Can the second opinion be obtained from outside the HMO at no extra cost? ____Yes ____No

10. Choosing your doctor:

Will you be allowed to choose your personal HMO doctor?
____Yes ____No

Will your choice be restricted in any way? ____Yes ____No

Will you be allowed to change your physician if you are unhappy with the one you selected? ____Yes ____No

Is there a limit on how often you can switch HMO doctors?
____Yes ____No

11. What type of staff handles routine office visits?
Physician _____; Nurse Practitioners _____;
Physician Assistants _____.

12. What provision is made if the HMO is not affiliated with a specialist you might need? _____
13. What coverage is available for family members who are students living outside the service area? _____
14. Under what conditions would an abortion or sterilization be covered under this plan? _____
15. What is the usual waiting period for an appointment with your doctor? _____
16. What are the office hours of the HMO? _____
17. What provisions are made for emergency care or for receiving care when the central location is closed? _____
18. EMERGENCY CARE:
- How does the HMO define emergency care? _____
- Is emergency care coverage limited to life-threatening situations when within the service area? ____Yes ____No
out of the service area? ____Yes ____No
- Does the plan pay for necessary ambulance service?
____Yes ____No
- How will you obtain health care services when traveling or visiting outside the HMO service area? _____
- Are you covered if you are out of the country? ____Yes ____No
- Is permission required for non-emergency care when you are outside the HMO service area? ____Yes ____No
- How long will it take to be reimbursed for expenses for care received while outside the service area? _____
- What records must be submitted to obtain payment for care received while outside the service area? _____
19. Under what conditions can you drop membership? _____
- Can you rejoin the HMO if you leave the area and return?
____Yes ____No
20. If you move out of the service area, how could you provide for health care costs in another community or state? _____
21. What provision is made to cover hospital and other costs if the HMO were to become insolvent? _____

22. Consumer Representation:

Does the HMO have an advisory committee made up of consumers?

Are consumers represented on the HMO Board of Directors?

____Yes ____No

23. Does the HMO have a grievance procedure and how does it work?

____Yes ____No

How does it work? _____

Below are some questions you may choose to ask HMO members:

	<u>YES</u>	<u>NO</u>
1. Do the physicians and other care providers treat you with courtesy and deal with you at a level you can understand?	_____	_____
2. Do you have access to doctors when necessary?	_____	_____
3. Are appointments for urgent care scheduled promptly?	_____	_____
4. Is the waiting period for routine check-ups reasonable?	_____	_____
5. Is it reasonably easy to call to make an appointment or ask a question?	_____	_____
6. Can you call your HMO doctor or physician extender when you have a question about your care?	_____	_____
7. Do you feel the HMO fairly and adequately covers the cost of what you believe is emergency care?	_____	_____
8. Would you recommend membership in an HMO to others?	_____	_____

Adapted From: Guide To Health Maintenance Organizations in Wisconsin, Cooperative Extension Service and School of Family Resources and Consumer Sciences, University of Wisconsin-Madison, 1984. Reprinted with permission.

HEALTH MAINTENANCE ORGANIZATIONS
(HMO'S)

- ALTERNATIVE TO TRADITIONAL
HEALTH INSURANCE
- PROVIDE BOTH HEALTH INSURANCE
AND SERVICES THROUGH SINGLE
ORGANIZATION
- PROVIDE COMPREHENSIVE HEALTH
CARE TO MEMBERS FOR A SET
PREPAID PREMIUM
- CARE PROVIDED BY HMO AFFILIATED
DOCTORS AND HOSPITALS
- PRIMARY CARE PHYSICIAN DETERMINES
CARE AND SERVICES REQUIRED

HEALTH MAINTENENCE ORGANIZATIONS
(HMO'S)

TWO MODELS

STAFF - DOCTORS ARE EMPLOYED AS A GROUP (staff) TO SEE MEMBERS AT HMO'S OWN FACILITIES OR AT HOSPITALS UNDER CONTRACT WITH THE HMO.

IPA'S - INDEPENDENT PRACTICE ASSOCIATIONS WHICH CONTRACT WITH DOCTORS IN THE COMMUNITY WHO TREAT MEMBERS OUT OF THEIR OWN OFFICES AND AT THE HOSPITALS DOCTORS ARE AFFILIATED WITH.

ADVANTAGES OF HMO MEMBERSHIP

- ONE PREMIUM WITH FEW OUT-OF-POCKET COSTS
- ELIMINATION OF CLAIM FORMS
- IMPROVED COORDINATION OF SERVICES

DISADVANTAGES OF HMO MEMBERSHIP

- MORE LIMITED CHOICE OF
DOCTORS AND HOSPITALS
- COVERAGE WHEN TRAVELING
LIMITED TO HMO-DEFINED
EMERGENCIES

PREFERRED PROVIDER ORGANIZATIONS
(PPO'S)

- ALTERNATIVE TO TRADITIONAL HEALTH INSURANCE
- LIKE HMO'S, COMBINE HEALTH CARE FINANCING AND SERVICES
- DOCTORS AND/OR HOSPITALS WHO CONTRACT TO PROVIDE HEALTH CARE TO SUBSCRIBERS FOR A NEGOTIATED FEE
- GROUPS CONTRACTED WITH INCLUDE EMPLOYERS, INSURERS, LABOR UNIONS
- COST SAVINGS ACHIEVED BY PEER REVIEW AND STRICT USE CONTROLS
- ALLOW SUBSCRIBERS TO RECEIVE CARE OUTSIDE THE PPO, EVEN FOR NON-EMERGENCIES
- MEMBERS HAVE FINANCIAL INCENTIVES, SUCH AS ELIMINATION OF DEDUCTIBLE AND CO-INSURANCE REQUIREMENT IF PPO PROVIDERS ARE USED

WHEN CHOOSING AN HMO OR A PPO CONSIDER THESE STEPS:

- COMPARE SERVICES AVAILABLE
- DETERMINE IF CHOICE OF CAREGIVERS IS ACCEPTABLE
- DECIDE IF LOCATION OF CAREGIVERS IS CONVENIENT
- DETERMINE QUALITY
- COMPARE COSTS
- KNOW REGULATIONS FOR OUT-OF-TOWN COVERAGE
- CHECK FINANCIAL STABILITY
- SEEK RECOMMENDATIONS FOR SUBSCRIBERS
- VISIT FACILITY AND TALK TO STAFF



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The Ohio State University

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SECTION II-C

PREFERRED PROVIDER ORGANIZATIONS

Unlike HMOs, there is no legal definition of Preferred Provider Organizations (PPOs), a concept which combines health care financing and services. Essentially, a preferred provider organization is a group of doctors and/or hospitals who contract with a group, such as an employer, insurer, or union, to provide health care to subscribers for a negotiated, usually discounted, fee. PPOs use peer review and strict utilization controls (pre-admission screening, concurrent review of hospitalized patients and retrospective claims reviews) to achieve cost savings.

PPOs are sometimes described as fee-for-service, independent practice-association (IPA) type health maintenance organizations. Unlike most HMOs, however, PPOs allow subscribers to receive care outside of the plan, even for nonemergency reasons. However, PPO patients have financial incentives, such as elimination of the deductible and co-insurance requirement, if care is received from PPO providers.

The following PPOs, all available through groups only, are operating in the Greater Cleveland area (no endorsement intended):

OHIO HEALTH CHOICE PLAN
Suite 310
2322 East 22 Street
Cleveland, OH 44115
216/363-2501

THE EMERALD HEALTH NETWORK
7530 Lucerne Drive
Middleburg Hts., OH 44130
216/243-2030

PREFERRED CARE OF OHIO
2060 East 9 Street
Cleveland, OH 44115
216/687-6056

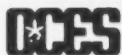
Unlike HMOs there are no federal standards for PPOs. If you are faced with the decision to sign up for a PPO, keep the following key points in mind:

- * Find out what doctors are on the approved list of providers. If you have a relationship with a physician, are you willing to switch doctors? What specialists could be used? What happens if you choose a doctor or facility outside of the PPO?
- * Is there a mechanism to voice legitimate complaints (patient-grievance procedure)?
- * Is the plan as comprehensive as the one you are giving up?
- * Are pre-existing conditions covered?
- * What is the coverage if you get sick or hurt out-of-town? What about away-from-home nonemergency benefits?
- * How long has the PPO been in operation?
(an indication of how financially sound it is)

As with any service, it is a wise idea to seek recommendations from subscribers (relatives, friends, co-workers) who use the PPO you are considering.



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III. EVALUATING AND SELECTING HEALTH CARE PLANS AND POLICIES

This section is designed to help individuals and families in evaluating, comparing, and selecting the best health care coverage available to them in order to get the most protection for dollars spent.

CONSUMER OBJECTIVES:

After completion of this section of leader training, participants should be able to:

1. Recommend one procedure for evaluating and comparing policies and plans.
2. Choose an example of a policy or plan that could meet their health care needs and cite two reasons to support that choice.
3. Cite four "tips" for consumers to consider in order to increase value for dollars spent on health care coverage.

LEADER TEACHING GUIDE

III. EVALUATING AND SELECTING HEALTH CARE PLANS AND POLICIES

A. GUIDELINES FOR SELECTING A HEALTH INSURANCE POLICY

Lesson Outline

Buying health care coverage is a major consumer purchase. Consumers must be comparison shoppers. The major considerations are:

I. Reliability of Company

A. Financial Stability

1. Check rating in Best's Insurance Reports - available in reference section of Cuyahoga County Public Libraries.

2. Should be one of two highest ratings.

B. State Licensing - call Ohio Department of Insurance to be sure.

C. Loss ratio - does the company return at least 50% of premiums in benefits?

D. Seek Recommendations

II. Understand Policy's Provisions

A. Dependent Coverage

1. Who is covered?
2. From birth? To what age?
3. For what benefits?

B. Effective Date

C. Exclusions and other limits on coverage

1. Waiting Periods - between effective date and start of coverage

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review "Guidelines for Selecting A Health Insurance Policy."

On board or flip chart, outline and discuss major considerations (or use Exhibits III-A & B, "Selecting A Health Insurance Policy," to display or use as transparencies.

Distribute handout "Health Insurance Policy Checklist" for participants to use at home to evaluate prospective policies.

2. Pre-existing conditions - exclude coverage entirely or for a period of time. Various definitions:
 - a. symptoms
 - b. condition for which medical treatment was received or recommended
 - c. condition which shows itself within a certain period of time
 - d. an unknown condition

Shop for policy with shortest exclusions for pre-existing conditions.

3. Riders - attachments which take away benefits
 4. Other exclusions - examples:
 - a. military service injuries
 - b. self-inflicted injuries
 - c. experimental procedures
 - d. hazardous sports
- D. Conversion Privileges - ability to convert a group policy to a guaranteed individual or family plan without a medical screening or waiting period.
- E. Renewal Provisions - ideally, policy should be noncancellable and, at buyer's option, renewable. Possible types:
1. Term or nonrenewable
 2. Conditionally renewable - company can decline to renew contract under certain conditions (e.g., deteriorating health) and can change rates
 3. Guaranteed renewable - insured can renew until specified age. Premium rates can be changed for class of insureds only
 4. Noncancellable - company can't change, cancel, or refuse to renew policy. Premium rates can't be changed unless policy provides scheduled rate increases with age.

Ask participants for examples of pre-existing conditions - list on board or chart.

Warn participants not to confuse this provision with attempts by some salespeople to convince clients to "convert" old policies to new and better ones.

Display and discuss Exhibit III-C, "Policy Renewal Provisions" (may be made into a transparency).

F. Limitations on choice of care givers usually to those associated with plan.

G. Coordination of Benefits - limits payments so that the total paid under all contracts does not exceed total cost of medical expenses.

H. Deductible - out-of-pocket amount insured must pay before benefits begin.

1. Higher deductible = lower premiums

2. Can apply to a period of time or each illness

3. Per family member and/or a total family amount

4. Only cost of covered benefits can meet deductible

a. Can apply cost of noncovered medical costs towards tax deduction

I. Co-insurance - percent of covered medical expenses (after deductible) paid by insurance company and/or insured. Look for policies with a maximum of 20% paid by the insured.

J. Stop-loss provision - maximum on total out-of-pocket expenses.

K. Maximum Level of Lifetime Benefits - Experts recommend at least \$250,000.

L. How Benefits Are Paid -

1. Service - Pay all necessary and reasonable charges (after deductible and subject to co-insurance clause)

2. Service with Maximum - up to a specified amount listed for each covered service

Distribute handout "Determining Your Out-of-Pocket Expenses for Health Care" for participants to use at home to estimate their costs.

Work out the following example with the class:

Mr. Jones receives a bill for \$250 from his doctor for a series of office visits for an illness. The bill includes \$50 in lab tests. His coverage includes a \$100 deductible per family member and 80% co-insurance for all other "reasonable charges." Lab tests are fully covered. What does Mr. Jones have to pay out of his own pocket?

Total Bill	\$250
Minus Lab Fee	50

Doctor's Fee	\$200
Deductible	- \$100

Balance	\$100
---------	-------

80% Paid by Insurance Co.	- 80
---------------------------	------

20% Paid by Mr. Jones	\$ 20
-----------------------	-------

Total Out-of-Pocket Costs	\$120
---------------------------	-------

Will he have to pay the deductible the next time he receives a bill for covered charges? NO

Will he have to pay the 20% co-insurance? YES

3. Schedule of Benefits or Indemnity Plan - pay specific dollar amount per day in hospital or each procedure

- M. Inpatient or Outpatient benefits - certain services may be received in certain settings only.

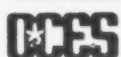
SUMMARIZE THIS LESSON BY COVERING THE FOLLOWING TIPS FOR BUYING PRIVATE HEALTH INSURANCE:

- A. Complete application completely and honestly.
1. Do not be pressured
 2. Review application attached to policy to be sure it is correct
- B. Be sure agent is licensed in Ohio.
1. Ask to see license
 2. Be sure it is a license to sell health insurance.
- C. Do not pay premium in cash.
- D. Do not buy based solely on advertising or a famous person's endorsement.
- E. Be sure company is licensed to do business in Ohio.
- F. Beware of scare tactics like, "last chance to enroll."
- G. Be careful about replacing existing policies.
1. May have to take a physical or satisfy new waiting periods
 2. Keep old policy until new one takes effect.
- H. Check for pre-existing conditions or waiting periods.
- I. Be sure there is a "free look" provision which allows the return of the policy within a certain number of days.
- J. Check renewability of policy.

Review "Tips for Buying Private Health Insurance" - duplicate, distribute, and review with class.



Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

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SECTION III-A

GUIDELINES FOR SELECTING A HEALTH INSURANCE POLICY

When buying health care protection, it's just as important to comparison shop as it is when buying a car. Listed here are important points which should be checked before deciding what policy is best.

RELIABILITY OF COMPANY

Health insurance is written by more different types of organizations than any other type of insurance. Several ways in which you can check the overall reliability of a company include:

* Financial Stability - Best's Insurance Reports - Life/Health, published annually and available in the reference section of Cuyahoga County Library, rates insurance companies. A high rating from Best's means the company is less likely to go broke. Look for one of the two highest ratings from Best's - "most substantial" and "very substantial" (Blue Cross/Blue Shield Associations are not included in Best's).

* State Licensing - Experts recommend that you only buy policies from companies licensed to do business in Ohio. In that way, the Ohio Department of Insurance can be of assistance if you have a problem with a company or claim. To find out if an insurance company is licensed in Ohio, call the Ohio Department of Insurance's Hot Line (toll free) at 800/282-4658 and ask for the Policyholders Service Division.

* High Loss Ratio - The loss ratio, or benefit-cost ratio, is the amount of funds collected in premiums that are returned to the insured persons. When selecting a company, look for a high return (a high loss ratio). Some experts believe that health insurance should not be purchased from a company who returns less than 50% of the premiums as

benefits. To check the loss ratios of companies, contact:

Argus Chart of Health Insurance
National Underwriter Company
420 East 4 Street
Cincinnati, OH 45202
513/721-2140

* Seek Recommendations - You want a company that will pay your claims promptly, fairly, efficiently, and courteously. Ask your relatives, friends, and co-workers what kind of service their companies have given them. Another source to ask are people who file claims, in doctor's offices for example, who are likely to have first-hand experience on how well claims are paid.

UNDERSTAND THE POLICY'S PROVISIONS

In addition to the company, consumers must be sure that they know and understand the terms of the policy which is, in effect, a written contract that outlines both benefits and obligations.

* Dependent Coverage - Know who is covered and at what age benefits begin and end. Infants should be covered from birth. Other children are usually covered until 19 years of age or sometimes longer if full-time students. Coverage is usually dropped automatically when children reach the maximum age listed in the contract, marry or enter the armed forces, but some policies continue coverage for totally disabled or handicapped children as long as they are dependent.

* The Policy's Effective Date - Not necessarily the date you apply, unless a binder is given and money is exchanged.

* Exclusions and Other Provisions Which Limit Coverage - It is very important to know what services, conditions and/or circumstances are delayed from being covered or are not covered by the policy, such as:

Waiting Periods - sometimes called "probationary periods," after your policy is in effect during which time your policy will not cover a given problem or condition. A waiting period can be between 15 and 30 days for any illness to be covered or can be as long as 12 months, as is often the case with maternity benefits.

Pre-existing Conditions - any illness or possibly symptoms you may have had before the policy was issued. Some policies don't cover such conditions at all; some specify a waiting period before you can collect. Still other policies have an automatic waiting period for collecting on claims for certain illnesses, pre-existing or not. Do not believe that because you are not required to take a physical or give a medical history that you will be covered for conditions you already have. Pre-existing conditions may be defined differently by various companies. They may mean any of the following:

- the existence of symptoms that could have required treatment.
- a condition for which medical treatment was received or recommended.
- a condition that shows itself within a certain period of time.
- a condition you did not even know you had before you bought your policy.

Ask how many years the company will go back in looking for pre-existing conditions (it could be as far as birth!). Ask how many years the policy will exclude paying benefits for pre-existing conditions after the policy's effective date. Shop for the policy with the shortest possible exclusion for pre-existing conditions.

NOTE: Information about health insurance histories is kept by the Medical Information Bureau (MIB). A list of past insurance you have had or been denied, and why, is compiled. Each history also lists the claims you have made with the illnesses and conditions that required those claims. The MIB is used by insurance companies when reviewing applications. And is, in some cases, the cause of an application for insurance being denied. You can get a copy of the information on file about you by request. Medical information is sent to the doctor you specify and non-medical information can be sent directly to you. Contact:

Medical Information Bureau
Disclosure Office
Essex Station
P. O. Box 105
Boston, MA 02112

If you find that the information is incorrect or out-of-date, you can ask for an investigation. If the incorrect information is not changed, you can have a "statement of dispute" placed in your file to be included whenever requests for information about you are made.

Riders - are attachments that take away benefits described in the policy itself. By law, a separate rider for each condition excluded must be attached to printed policies. Although riders reduce benefits, premiums are not usually reduced accordingly.

Other Exclusions - health insurance policies usually exclude illness or injury resulting from:

- War or military service
- Attempted suicide or self-inflicted injuries

- Injury or illness covered under Workers' Compensation
- Treatment received in government hospitals (VA, military, or federal institutions)
- Aviation (under certain circumstances)
- Hazardous sports (i.e., race car driving)
- Experimental procedures
- Criminal acts such as committing a felony
- Coverage outside of United States and Canada

* Conversion Privileges - group contracts contain a clause that allows an employee, when leaving a job or in the case of marriage, death, or divorce of spouse, birth of a child or a child reaching maximum age, to convert all or part of the contract to a guaranteed individual or family plan, sometimes at a cost lower than buying a new individual policy. Such policies could be more comprehensive. By converting an existing policy rather than buying a new one, you don't have to take a physical and you don't have to worry about any waiting periods before coverage begins. There is usually a time limit of 15 to 31 days during which the conversion privileges may be exercised.

TIP: Do not confuse this legitimate provision in a policy with an attempt to convince you to "convert" or rewrite the policy you have to a new and different one. Be very cautious before you cancel or change policies because you may be left with no coverage or coverage that is significantly reduced, often with higher costs. If you are asked to complete a new application, you are applying for a new policy. Benefits to an existing policy may be supplemented by the company simply by adding an amendment.

* Renewal Provisions and Changing of Premium Rates - Individual policies are written for a limited time, usually a year, and must be renewed at the end of each term. Ideally, the policy should be non-cancellable and, at your option, renewable either indefinitely or until you qualify for Medicare. A non-cancellable policy will cost more since the company assumes greater risk. However, without this feature, the company would be able to terminate your coverage if you have large medical bills.

* Limitations on Services of Care Givers - Some plans limit your choice of physician, hospital, or other place of care to those associated with the insurance plan. Some plans pay "member doctors" in full and other doctors only in part. Know what your choices will be.

TIP: Look for policies that do not impose limitations when the insured person is traveling in the United States. Also, if you travel to other countries, look for contracts that will pay for medical care wherever it is received and be sure this is written into the agreement.

* Coordination of Benefits - When an individual is eligible for benefits under more than one contract or policy, a coordination of benefits provision may be included. This limits payment so the total amount paid under all contracts does not exceed the total medical expenses incurred.

* The Deductible Amount - Know the amount of money you must pay out-of-pocket before your insurance benefits begin. Usually, the higher the deductible, the lower the premium. Find out if the deductible applies to each separate illness or to a calendar or policy year. The deductible may be for each person covered by the policy in which case there is usually a single sum for the family as a whole. Remember that only the cost of covered benefits can be used toward the deductible. If, for example, your policy does not cover the cost of routine physical exams, the money spent on one will not be included as part of your deductible (you can, however, apply those non-refundable costs towards your tax deduction for medical expenses).

TIP: Some experts feel that a low deductible in an individual policy may not be a better bargain over the long run and may end up costing more than those with higher deductibles. They suggest you use the following as a general rule of thumb when comparing policies: if the difference in monthly premiums over an 18-month period is greater than the difference in the amount of the deductible, you are better off with the policy that has the higher deductible.

* Co-insurance - The provision that specifies how you and the insurance company will share the payment of covered services, expressed as a percentage. Co-insurance begins after your expenses which are allowable (covered) have surpassed the deductible amount. Some experts believe you should not buy a policy in which the co-insurance amount exceeds 20%. A co-payment is a specific dollar amount, similar to a deductible, but is only charged in certain defined situations. Co-payments are most commonly charged for doctors' visits for maternity care.

* Stop-loss Provision - A maximum on your total out-of-pocket expenses. The higher the amount, the lower the premium. It is important, however, to find out whether this rule applies when your total medical expenses reach the specified amount or only when the portion you have been paying out of your own pocket goes that high.

* Maximum Level of Lifetime Benefits - The maximum amount the company will reimburse you for covered medical costs. Some policies have a feature called an "annual restoration provision," which reinstates a portion of the lifetime maximum on an annual basis. The Health Insurance Association of America recommends you buy a policy with a maximum level of at least \$250,000.

* How Benefits Are Paid - Generally, benefit payments fall into one of three categories:

- Service Benefits - recommended by many experts, pay all necessary and reasonable charges subject to any deductible or co-insurance clauses in the policy. Payment may be made directly to the hospital or physician, or to the insured.

- Service Benefits with Specified Maximum pays up to a specific maximum amount, usually listed in the policy, for each covered service. If the actual cost is less than the stated amount, the policy pays the actual (lesser) amount. If the actual cost is more than the policy provides, the insurer pays the amount stated in the policy and you, the insured, must pay the difference.

- Scheduled Benefit or Indemnity Plans pay a specific dollar amount for each day in the hospital or each medical procedure. These plans pay cash to the insured who can use the money as desired. Often, the specific amounts paid by these plans are well below what actual charges are, so caution needs to be exercised if the plans you are considering will be your only form of coverage.

* Inpatient and Outpatient Benefits - Be sure you understand what procedures are covered and in what setting. Since so many procedures today are being done on an outpatient basis (you are not admitted to a hospital), be sure to check these areas carefully. Comparison worksheets found in this kit will assist you when reviewing a policy or plan.

References:

Cornacchia, Harold and Stephen Barrett. Shopping For Health Care. New York: Mosby, 1982.

Denenberg, Herbert. Getting Your Money's Worth. Washington, D.C.: Public Affairs Press, 1974.

Gregg, John E. The Health Insurance Racket and How To Beat It. Chicago: Henry Regnery Co., 1973.

Berman, Henry; Diane Burhenne and Louisa Rose. The Complete Health Care Advisor. New York: St. Martin's/Marek, 1983.

"Does Your Medical Insurance Really Cover Enough?" Changing Times. October 1980. Vol. 34, No. 10, p. 37-39.

"How Good Is Your Health Insurance?" McCalls. April 1980. Vol. CVII, No. 7, p. 72-80.

"Making Sense of Health Insurance." Diabetes Self-Management. Winter 1984-85. p. 4-8.

EXHIBIT III-A

SELECTING A HEALTH INSURANCE
POLICY

• RELIABILITY OF THE COMPANY

~ Financial Stability

~ State Licensing

~ Payment of Claims

~ Loss Ratio

EXHIBIT III-B

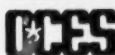
SELECTING A HEALTH INSURANCE
POLICY

• UNDERSTAND POLICY'S PROVISIONS

- ~ Dependent Coverage
- ~ Effective Date
- ~ Exclusions and Other Limitations
 - ♦ Waiting Periods
 - ♦ Pre-existing Conditions
 - ♦ Riders
 - ♦ Other Special Exclusions
(I.E. Experimental Procedures)
- ~ Conversion Privileges
- ~ Renewal Provisions
- ~ Limitation on Choice of Care Givers
- ~ Coordination of Benefits
- ~ Deductible Amount
- ~ Co-insurance Amount (As A Percentage)
- ~ Stop-Loss Provision
- ~ Maximum Level of Lifetime Benefits
- ~ How Benefits Are Paid
 - ♦ Service
 - ♦ Schedule of Benefits (Indemnity)



Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



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SECTION III-A

HEALTH INSURANCE POLICY CHECKLIST

When considering a health policy, use this checklist to be sure you are buying an adequate product that will meet your needs. Refer to "What You Should Look For In Health Insurance" for more information on each of these factors.

I. Reliability of Company

- A. Financial Stability. Has the company selling the policy received one of the two highest ratings from Best's Insurance Reports (most substantial or very substantial)?

_____ Yes _____ No

- B. Is the company licensed to do business in Ohio?

_____ Yes _____ No

- C. What is the company's loss ratio?

_____ %

- D. Do you know anyone who has filed claims and recommends the company?

_____ Yes _____ No

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Prepared by Lindell C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service.
The Ohio State University, 6/86.

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Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture, J. Michael Sprott, Director of Ohio Cooperative Extension Service, The Ohio State University.

II. Policy's Provisions

A. Dependent Coverage. What family members would be covered?

Are newborn babies covered from birth? ☐ Yes ☐ No
To what age are children covered? _____

B. Exclusions:

1. How long is the waiting period before benefits start? _____
2. Are there exclusions for pre-existing conditions?
☐ Yes ☐ No
If yes, what conditions? _____
3. Are there any riders or amendments attached to the policy? ☐ Yes ☐ No. If yes, what benefits are taken away?

- C. Is the policy guaranteed renewable? ☐ Yes ☐ No
Is the policy non-cancellable? ☐ Yes ☐ No

- D. Is there a limit on your choice of physicians, hospitals or other places of care? ☐ Yes ☐ No

- E. How much is the deductible? per individual \$ _____
Family maximum \$ _____.

- F. How much is the co-insurance? _____%

- G. What is the maximum (stop-loss) out-of pocket amount of covered expenses you would pay? \$ _____

- H. What is the maximum level of benefits over a lifetime?
\$ _____

- I. How are the benefits paid? ☐ Service Benefits or
☐ Indemnity Plan

- J. Is coverage for certain procedures limited to inpatient (in-hospital) settings? ☐ Yes ☐ No

If yes, are they more likely to be done on an outpatient basis? ☐ Yes ☐ No

EXHIBIT III-C
POLICY RENEWAL PROVISIONS

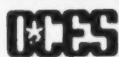
TYPE OF PROVISION	MEANING
Term or Nonrenewable	Policy cannot be renewed.
Optionally Renewable	Policy can be renewed. Insurance company can decide not to renew but may only cancel at certain times, such as when premiums are due. Premium rates can be changed.
Conditionally Renewable	Insured can renew until a specified age subject to the insurance company's right to decline renewal under conditions specified in the contract. Usually renewal would not be denied if the insured's health had deteriorated. Premium rates can be changed.
Guaranteed Renewable	Insured has the right to renew until a specified age. Premium rates can be changed for a class of insureds, but not just for an individual.
Noncancellable	Insurance company cannot change, cancel or refuse to renew the policy if premiums are paid on time. Premium rates cannot be changed. The policy can provide for scheduled rate increases as the insured gets older.

SOURCE: VIRGINIA HEALTH INSURANCE CONSUMER'S GUIDE, 1983



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SECTION III-A

DETERMINING YOUR OUT-OF-POCKET EXPENSES FOR HEALTH CARE

Here is a list of some of the payments you have to make:

INSURANCE OR PLAN PREMIUM - The price of the premium is determined by the age and sex of the applicant, the extent of coverage, and the presence and size of a deductible and co-insurance. Health insurance premiums and costs of joining alternative plans have been increasing in recent years. In 1984, comprehensive group family health insurance policies generally cost \$1,500 to \$3,500. Individually purchased plans can be 15% to 40% more expensive than group coverage. How much are you contributing toward health care protection?

\$ _____ yearly \$ _____ monthly x 12 = \$ _____

DEDUCTIBLE - The dollar amount of medical expenses you must pay each year before the insurance policy starts paying.

My yearly deductible (the amount which I must budget for) is:

_____ Per Individual _____ Family Total

Does your policy allow expenses incurred at the end of the year to be carried forward as part of the deductible for the following year?

_____ Yes _____ No

CO-INSURANCE - The percentage of covered expenses you must pay is _____%.

CO-PAYMENTS - Does your policy require a specific amount of money to be paid by you for specific procedures, such as x-rays, office visits, inoculations?

_____ Yes _____ No

COORDINATION OF BENEFITS - Is your spouse covered by another health insurance plan which may result in additional reimbursement to you of your medical expenses?

_____ Yes _____ No

HOW BENEFITS ARE PAID - If your plan pays on an INDEMNITY basis, how much will it pay you for each day of hospitalization? \$_____ How does this compare to average hospital room rates in your area? (In 1984, the average cost for a semi-private room in Ohio was \$228; Cleveland is higher). How many days in the hospital would be paid for under this policy? _____

SERVICE benefits are, on the other hand, can be authorized by the insured to be paid directly, and are usually for the full cost of a semi-private room, board and in-hospital services, or to the doctor, providing the hospital or doctor is a member, a "participating" provider who has agreed to accept the reimbursement rate negotiated by the insurance company.

POLICY MAXIMUM (STOP-LOSS PROTECTION) - Does your policy set a maximum out-of-pocket dollar amount that you must pay in a calendar year before your policy picks up 100% of covered charges at the UCR level? _____ Yes _____ No If yes, my maximum expense is \$_____ (NOTE: Charges that the insurer says are in excess of reasonable and customary fees are excluded from the out-of-pocket limit.)

REASONABLE AND CUSTOMARY FEE STIPULATION - Typically a policy will pay 80% of up to what is considered the "going rate" for identical or similar services within a specific geographic area (after the satisfaction of the deductible). If your doctor charges fees in excess of what the insurer considers "reasonable and customary," you pay the difference. In large urban areas such as Cuyahoga County, fees can vary widely.



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SECTION III-A

TIPS FOR BUYING PRIVATE HEALTH INSURANCE

Complete the application completely and honestly. A written application is necessary to buy health insurance. Alone it does not constitute a contract to provide coverage, but it is a critical first step in securing protection. Do not withhold medical information. Since claims forms often request the same information, it is critical that the original application include essential facts of your health history or future claims may not be paid.

* DO NOT allow yourself to be pressured into signing an application without reviewing what has been written.

* Carefully review the copy of the application attached to the policy to be certain that it is correct and has not been altered in any way. If you find a mistake, notify the company in writing.

Be sure agent is licensed to sell health insurance in Ohio. Ask to see a copy of his or her license before signing the application

DO NOT PAY CASH. Make premium payments by check or money order made out to the insurance company, not the agent.

Do not make a decision to buy based solely on advertising on TV, radio, or newspaper or an endorsement by a famous person.

Be sure the insurance company is licensed to do business in Ohio. Contact the Ohio Department of Insurance (toll-free) 1-800-282-4658.

Beware of "Scare Tactics." Do not be high-pressured into buying a policy. Avoid buying under the pressure of limited enrollment periods or "last chance to enroll."

Be careful about replacing existing policies. You may have to take a physical exam or satisfy new waiting periods. If you need improved coverage, see if you can upgrade a current policy first or keep it until a new policy becomes effective.

Check for pre-existing condition exclusions and waiting periods.

Make sure there is a "Free Look" provision giving you at least ten days from when an individual policy is received to review it. If it is not what you expected or you decide you don't want or need it, or can't afford it, return it promptly by certified mail. Enclose a request in writing for a full refund of the premium with the reason for your request. Always keep a copy of your letter.

Check your right to renew the policy.

LEADER TEACHING GUIDE

III. EVALUATING AND SELECTING HEALTH CARE PLANS AND POLICIES

B. COMPARING HEALTH INSURANCE POLICIES AND PLANS

Lesson Outline

Today consumers are being faced with many options in the purchase of their health care. Competition among providers and plans for limited dollars has increased the number of choices and contributed to consumer confusion.

Employers, in order to stop or reduce escalating costs, often offer choices to their employees regarding health care coverage. These choices usually are among traditional fee-for-service private health insurance plans, HMOs and/or PPOs. Some employers offer a "cafeteria plan" where employees can select individual programs, including health care coverage, from a "menu" of benefits.

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review "Changes In Health Care: What You and Your Family Should Know" by the Ohio State Medical Association (Copy in Overview Section).

Secure samples of policies or explanation of benefits from:

Private Health Insurance
Companies
HMO Plans
PPO Plans

Duplicate and distribute Policy/Plan Comparison of Benefits Worksheet to participants.

Divide class into small groups and ask each group to fill in the worksheet for a policy or plan. Allow time to compare. (If time is short, Make Exhibit III-D into a transparency and fill in worksheet as a group.)

SECTION III - B



POLICY/PLAN COMPARISON OF BENEFITS WORKSHEET

OTYLANDA COUNTY
COOPERATIVE EXTENSION SERVICE
1200 West 60 Street
Cleveland, Ohio 44115
(216) 821-1000
(216) 821-3000

Many employers are now offering choices to their employees regarding health care coverage. Use the chart below to help compare what would be covered under each option before you make a decision. You should contact your employee benefit specialist or personnel department with specific questions. This worksheet can also be used by persons who must secure individual health care.

DIRECTIONS: A list of provisions or benefits included in many plans is provided in column I. It is not meant to be all inclusive. The types of plans commonly offered by employers are listed in columns II-V. Write in the names of the plans your employer offers under the correct type. Review each plan and fill in the benefits described in each under each column. When completed, you will have a comparison that can be used to help you decide which plan best meets your family's needs.

COLUMN I	COLUMN II <u>INSURANCE</u> <u>COMPANY</u>	COLUMN III <u>BLUE CROSS/</u> <u>BLUE SHIELD</u>	COLUMN IV <u>HMO:</u>	COLUMN V <u>PPO:</u>
Monthly Premium				
• Individual:				
• Family:				
Annual Deductible				
• Individual:				
• Family:				
Co-insurance:				
Out-of-Pocket Maximum:				
Where Services Are Available:				
Services in Doctor's Office:				
• Initial Treatment of Injury or Life Threatening Illness				
• Treatment of Non- Life Threatening Illness or Follow-				
• Routine Physicals				

(over)

COLUMN I	COLUMN II <u>INSURANCE</u> <u>COMPANY</u>	COLUMN III <u>BLUE CROSS/</u> <u>BLUE SHIELD</u>	COLUMN IV <u>HMO:</u>	COLUMN V <u>PPO:</u>
• Diagnostic X-Ray and Lab Tests • Physical Therapy • Hearing Exams • Vision Care • Immunizations, Injections • Mental Health				
Services in Hospital • Room, Board, Drug and Other Hospital Services • Physician's Service in Hospital • Special Duty Nursing				
Pre-Admission and Concurrent Review				
Maternity				
Hospital Emergency Room Care • Illness • Accident				
Mandatory Second Opinion Elective Surgery Inpatient/Out-Patient Surgery Outpatient Lab and X-Ray Extended Care Facility				
Other Services • Ambulance • Home Health Care				
Prescription Drug				
Eligibility				

EXHIBIT III - D



POLICY/PLAN COMPARISON OF BENEFITS WORKSHEET

CUYAHOGA COUNTY
COOPERATIVE DETENTION SERVICE
3900 East 85 Street
Cleveland, Ohio 44105
(216) 831-1500
(216) 831-3100

Many employers are now offering choices to their employees regarding health care coverage. Use the chart below to help compare what would be covered under each option before you make a decision. You should contact your employee benefit specialist or personnel department with specific questions. This worksheet can also be used by persons who must secure individual health care.

DIRECTIONS: A list of provisions or benefits included in many plans is provided in column I. It is not meant to be all inclusive. The types of plans commonly offered by employers are listed in columns II-V. Write in the names of the plans your employer offers under the correct type. Review each plan and fill in the benefits described in each under each column. When completed, you will have a comparison that can be used to help you decide which plan best meets your family's needs.

COLUMN I	COLUMN II <u>INSURANCE</u> <u>COMPANY</u>	COLUMN III <u>BLUE CROSS/</u> <u>BLUE SHIELD</u>	COLUMN IV <u>HMO:</u>	COLUMN V <u>PPO:</u>
Monthly Premium				
• Individual:				
• Family:				
Annual Deductible				
• Individual:				
• Family:				
Co-insurance:				
Out-of-Pocket Maximum:				
Where Services Are Available:				
Services in Doctor's Office:				
• Initial Treatment of Injury or Life Threatening Illness				
• Treatment of Non- Life Threatening Illness or Follow- up Care for Treat- ment of Life Threatening Illness or Injury				
• Routine Physicals				

COLUMN I	COLUMN II	COLUMN III	COLUMN IV	COLUMN V
	<u>INSURANCE COMPANY</u>	<u>BLUE CROSS/ BLUE SHIELD</u>	<u>HMO:</u>	<u>PPO:</u>
• Diagnostic X-Ray and Lab Tests • Physical Therapy • Hearing Exams • Vision Care • Immunizations, Injections • Mental Health				
Services in Hospital • Room, Board, Drug and Other Hospital Services • Physician's Service in Hospital • Special Duty Nursing				
Pre-Admission and Concurrent Review				
Maternity				
Hospital Emergency Room Care • Illness • Accident				
Mandatory Second Opinion Elective Surgery Inpatient/Out-Patient Surgery Outpatient Lab and X-Ray Extended Care Facility				
Other Services • Ambulance • Home Health Care • Nutrition Assessment and Information		127		
Prescription Drug				
Eligibility				

LEADER TEACHING GUIDE

III. EVALUATING AND SELECTING HEALTH CARE PLANS AND POLICIES

C. GETTING THE MOST FOR YOUR HEALTH INSURANCE DOLLAR

Lesson Outline

Consumers should realize purchasing health insurance is like any other major consumer purchase. As a way of summarizing this leader guide section, review the following tips designed to help maximize health care dollars:

- A. Maintain healthful habits in order to need minimum medical care.
 1. Health habits can have a positive impact on underwriting decisions for individual policies.
 2. Some insurers or companies offer rewards (reduced premiums or cash incentives) for healthier habits (i.e., non-smoking).
- B. Shop Around - more options than ever
 1. Wide variety of coverages
 2. Wide variety of rates
- C. Purchase group coverage, if possible.
 1. Usually 15-40% less
 2. Review carefully to be sure rate is lower for same coverage

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review "Getting The Most For Your Insurance Dollar." Distribute and discuss with class (or make Exhibit III-E into a transparency).

Request additional suggestions from participants.

D. Avoid Duplicate Coverage For Same Services

1. Under coordination of benefits can't collect twice or more than 100%
2. Compare services covered carefully

E. Pay Premium Annually or Semi-annually

1. Usually pay less
2. Can pay monthly until satisfied with contract
3. Some companies allow "trial application" to determine insurability; if rejected, no record of denial.

F. Choose Large Deductibles If Dollars Are Limited

1. Policies with "first dollar" coverage very expensive
2. Self-insure for least expensive costs
3. Larger deductible = lower premium

G. Select Less Expensive Providers or Procedures

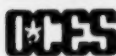
1. Outpatient procedures less expensive
2. Save on co-insurance

H. Plan Ahead

1. Schedule covered elective procedures and care in year when deductible has been met
2. Know what policy or plan requires to be reimbursed

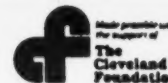


Making Sen\$e of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



SECTION III-C

GETTING THE MOST FOR YOUR HEALTH INSURANCE DOLLAR

MAINTAIN HEALTHFUL HABITS - the most obvious way to lower costs for medical care is to stay as healthy as possible so that you need minimum medical care. Health habits also play a part in underwriting decisions for individual insurance policies. Some insurers or companies offer reduced premiums or other cash incentives for healthier habits, non-smoking, for example.

SHOP AROUND - there are more options today for health coverage than ever before. This means that there is a wide variety of coverages and rates. Health care protection is a major purchase and should be approached in the same comprehensive way as other major consumer purchases.

PURCHASE GROUP COVERAGE, if possible. It is usually 15-40% less than an individual policy.

AVOID DUPLICATE COVERAGE - when filing an insurance claim, other policies you have must often be listed. Under "coordination of-benefits," you cannot collect the same benefits from two policies since the maximum that will be paid in most cases is 100% of the cost of the illness.

If a married couple work for different companies and one or both must pay a part or all of the premiums under the employers' health plan, it may be unnecessary for both to have family coverage. However, it could be beneficial to pay the extra premiums and coordinate benefits so that one policy fills in where the other leaves off. This is probably the least expensive way to supplement coverage.

PAY PREMIUM ANNUALLY OR SEMI-ANNUALLY - in general, the fewer payments you make will lower the total yearly premium. Ask to see a payment schedule, to be sure you are getting a lower rate. Some experts, however, recommend you pay monthly until after a contract is issued, and then you may exercise your 10-day free look option. Once a claim occurs, coverage is cancellable on a monthly basis after the fact.

A TRIAL APPLICATION is allowed by many companies to determine insurability. They may have a special form or may use the regular form on which is written "Trial Application - Make No Record Unless Accepted." If the application is rejected, this will prevent a record of the denial of the health insurance being added to your health insurance history.

TIP: Always pay your premium by check, money order or bank draft made out to the insurance company, not the agent or anyone else. Do not pay cash unless you get a bona fide receipt.

CHOOSE LARGE DEDUCTIBLES - policies which pay all costs from the first dollar are very expensive. Determine how much you can afford to pay out of current income and cash reserves, then choose a policy with the highest deductible you can afford.

SELECT LESS EXPENSIVE PROVIDERS OR PROCEDURES - today many medical procedures are being done on an out-patient basis or in urgent care or surgical centers. In fact, your coverage may require this for full payment for certain procedures or may provide a monetary incentive, such as waiving the deductible, if you utilize a less expensive option. In any case, you will save money if your plan requires a co-insurance payment by you.

PLAN AHEAD - by understanding how the deductibles and limitation of your plan work, you can maximize the coverage. For example, if medical expenses are running high one year, you might decide to get care you have been putting off but know you need because you have already met your annual deductible. If you have been healthy all year, you may choose to schedule the elective procedures for early the next year. Approach your insurance policy the way you do a tax return and use all legal ways you can to save money by making the rules and regulations work to your advantage.

TIP: For tax purposes, if you are close to exceeding 5% of your taxable income for medical expenses, you may want to schedule as much medical care as possible for one calendar year, since medical expenses are not deductible unless they exceed that amount.

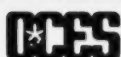
EXHIBIT III-E

GETTING THE MOST FOR YOUR
HEALTH INSURANCE DOLLAR

- MAINTAIN HEALTHFUL HABITS
- SHOP AROUND
- PURCHASE GROUP COVERAGE
- AVOID DUPLICATE COVERAGE
- PAY PREMIUM ANNUALLY
- CHOOSE LARGE DEDUCTIBLES
- SELECT LESS EXPENSIVE PROVIDERS
OR PROCEDURES
- PLAN AHEAD

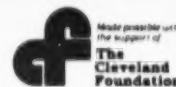


Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



IV. USING YOUR PLAN TO MAXIMIZE BENEFITS

This section is designed to assist consumers in following correct procedures for filing claims in order to receive reimbursement from their plans and in seeking appropriate assistance with complaints. It also provides information on how to utilize health care plans in order to receive full value and benefits.

CONSUMER OBJECTIVES:

After completion of this section of leader training, participants should be able to:

1. List three guidelines to keep in mind when filing health care claims in order to insure proper reimbursement.
2. Describe how to file a health insurance complaint.
3. Cite two general examples of procedures required by some health care plans in order to insure maximum reimbursement.

LEADER TEACHING GUIDE

IV. USING YOUR PLAN TO MAXIMIZE BENEFITS

A. How To File A Health Insurance Claim

Lesson Outline

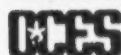
Suggested Learning Activities

- | | |
|--|---|
| I. Check ahead to be sure treatment is covered. | Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so. |
| II. Ask service provider to bill insurance company directly. | |
| A. Know extent of coverage. | |
| B. Know reimbursement process. | Review "Filing A Health Insurance Claim." |
| III. Have supply of correct claim forms. | |
| IV. File claims promptly. | On board or flip chart, outline major steps. |
| V. Discuss <u>wording</u> on form with the doctor. | |
| VI. Fill forms out correctly and completely; attach back-up. | |
| VII. Keep copies of <u>all</u> paperwork. | |
| VIII. Follow up, if necessary. | |
| A. Claims must be paid promptly <u>or</u> | |
| B. must receive a reply within 15 working days. | |



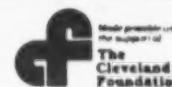
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SECTION IV-A

FILING A HEALTH INSURANCE CLAIM

The most important step, especially with the recent changes in many medical plans, is to understand your coverage. Your claims can only be fully paid if you follow the correct procedures required of your plan. Here are some guidelines:

1. Check ahead of time to see if a particular medical service or treatment is covered and to what extent it is covered. Your company or agent should be able to supply you with the necessary information.
2. Ask for your insurance company to be billed directly. You should know the exact extent of your coverage and the process for reimbursement in order to assist the hospital or physician's staff in honoring your request.
3. Make sure you have a supply of the correct claim forms. For some insurers or Blue Cross/Blue Shield Associations, your hospital or doctor may have the forms and may be able to file your claim for you.
4. File claims promptly. Most policies have a time limit on the filing of claims. If you have an agent, contact him or her to help you file your claim.
5. Discuss your coverage with your doctor or staff. The exact wording of the reason you saw the doctor may make a difference in whether your policy will pay or not.
6. Make sure you fill out the necessary form correctly and completely, and that you supply all necessary forms, such as an itemized bill from your doctor.

Prepared by Lindell C. Northrup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service, The Ohio State University, 6/86.

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Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture, J. Michael Sproff, Director of Ohio Cooperative Extension Service, The Ohio State University.

7. Keep copies of whatever you send to the insurance company, including a record of the date you filed the claim.

8. Ask how long it will take to be reimbursed and follow up promptly at the time specified if you have not been paid.

After the company is informed of your claim they should send you any needed forms and verify your claim. The Unfair and Deceptive Trade Practices Rule of 1975 requires prompt payment by insurers of justified claims, and prompt response (within 15 working days) of all policyholders' inquiries. If the company rejects your claim or pays only a part of it, you should be given an explanation for the decision.

If your claim is denied or only partially paid, you may want to seek assistance from some of the following sources, which apply to your particular situation:

1. Your agent or company representative;
2. Your employee benefits specialist;
3. Your union;
4. Your doctor;
5. The claims manager of your insurance company. See if there is a toll-free number for the claims department.
6. The professional, fraternal or labor group sponsoring your group plan;
7. Professional claims assistors, who charge a fee (usually per hour) for their work. In Cuyahoga County, two examples of this type of company include Claim and Help and Mediform.
8. Ohio Department of Insurance (refer to fact sheet, "How To File An Insurance Complaint.")
9. A private attorney.

LEADER TEACHING GUIDE

IV. USING YOUR PLAN TO MAXIMIZE
BENEFITS

B. How To File An Insurance
Complaint in Ohio

Lesson Outline

Suggested Learning
Activities

I. Why complain?

- A. Insurance company has improperly refused to issue or renew a policy.
- B. Claim is refused or only partly paid.

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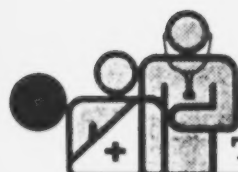
II. How?

- A. Contact agent or company representative first.
 - 1. Send letter
 - 2. Include all information
 - 3. Keep a copy
- B. Contact Ohio Department of Insurance who will investigate.
 - 1. Call toll-free phone
1-800-282-4658.
 - 2. Use form provided by Department of Insurance.
- C. If not satisfied, may take legal action.

Review "How To File An Insurance Complaint in Ohio."

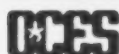
On board or flip chart, outline complaint procedure.

Write phone number on board or flip chart.
Display claim form.



Making Sense of Health Care Plans:

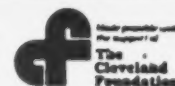
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SECTION IV-B

HOW TO FILE AN INSURANCE COMPLAINT IN OHIO

If you believe your insurance company has improperly refused to issue or renew your policy, or refused to pay all or part of a valid claim, you have a right to question and complain. Your first step is to contact your agent or company representative.

A complaint by letter is best. Always keep a copy. Include your name, address, telephone, policy number, type of policy and the nature of your complaint. If you decide to complain by telephone, keep a written record of your call, the name of the person you talked to at the company, and what was said during the call.

If you do not receive a response that you agree with, you may contact the Ohio Department of Insurance who will investigate and determine if the company is within the laws of the state. This consumer protection service is provided by the Department's Policyholders' Service Division which has a toll-free hot line available to all Ohio residents. When a written complaint is received, one of the Division's investigators is assigned to investigate and answer the consumer's complaints. To reach the department:

Ohio Department of Insurance
2100 Stella Court
Columbus, OH 43266

You may call the department's HOT LINE (toll-free)
1-800-282-4658, or use a form provided by the department.

If you are not satisfied with the results of the department's resolution of your complaint, you can consider taking legal action against the insurance company.

Prepared by Lindell C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service, The Ohio State University, 6/86.

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STATE OF OHIO
Department of Insurance
Policyholders Service Division
2100 Stella Court
Columbus, Ohio 43266

In response to your request for assistance we are sending this Insurance Complaint Form. Please complete and return it. We will then conduct an investigation and further advise you.

NOTE: If there is a File # shown in the For Department Use Only section it is only necessary to complete the items checked (☒).

Your Name Address Telephone: (Area Code) Insured:	For Department Use Only I.I.C. Code File # Date Received
---	---

SECTION A.	
1. Type of Insurance (please check one) ☐ Auto ☐ Fire or Home Owners ☐ Life ☐ Health ☐ Others _____	
2. (A) If your problem involves an insurance company, please give the full name of the company (not the agent or broker). _____ (B) If your problem involves an agent or broker, please give full name and address: _____	
3. My policy number is:	Claim number: (If known)
4. Date and location of accident or loss: _____	
5. This is my only report of this accident or loss to the Department. ☐ Yes ☐ No (A) If NO, date of previous report, _____	
6. I have attached copies of policies, correspondence, bills, etc. ☐ Yes ☐ No	

SECTION B. PLEASE CHECK THE STATEMENT(S) THAT APPLY TO YOUR PROBLEM.	
1. ☐ Claim Amount Dispute	6. ☐ Refund Due
2. ☐ Denial of Claim	7. ☐ Misquoted Premium
3. ☐ Delay in Settlement	8. ☐ Policy Not Received
4. ☐ Cancellation or Non-Renewal	9. ☐ Cash Surrender or Cash Value
5. ☐ Payment Not Credited	0. ☐ Other

(OVER)

Briefly and in your own words describe your problem. If more space is needed, please attach additional sheets.

[illegible]

PLEASE SIGN AND DATE THE STATEMENT BELOW:

To the best of my knowledge the information contained herein is correct. I understand that a copy of this form and attachments may be forwarded to the insurance company involved.

Signature	Date
-----------	------

LEADER TEACHING GUIDE

IV. USING YOUR PLAN TO MAXIMIZE BENEFITS

C. Health Care Coverage and the New Rules

Lesson Outline

Suggested Learning Activities

Many employers are implementing cost containment procedures, usually affecting:

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

I. Hospital admission

- A. Preadmission permission (called precertification) required for nonemergencies.
- B. Insurance company grants permission for a specific period of time or
- C. May recommend alternative treatment (i.e., ambulatory surgical procedure)
- D. No permission = no coverage or lowered coverage

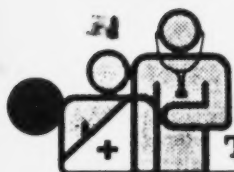
Review "Health Care Coverage and the New Rules."

II. Surgery (nonemergency)

- A. Second opinion required
- B. Company may provide names of doctors
- C. Cost fully covered
- D. Third opinion often covered
- E. If surgery is decided upon, plan may also require permission for hospitalization

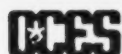
Display and discuss Exhibit IV - A. - Plan Design Options. Stress #2 and #5, the most common areas affected by change.

- III. If employed persons are both covered, correct procedures must be followed for secondary payer as well.



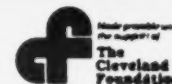
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SECTION IV-C

HEALTH CARE COVERAGE AND THE NEW RULES

In an effort to lower the cost of health care, many companies have new procedures which must be followed in order to receive full value from the plan. It is critical that you understand them before you need to use certain medical services.

The two areas which are the most likely to have been changed are hospital admission and surgery. A hospital review program usually requires what is known as preadmission certification, or obtaining the insurance company's permission before being admitted to the hospital for non-emergency care. Under this requirement, a patient or the physician must contact the carrier with the specific details of the diagnosis. The insurance company then decides whether to grant approval for the admission for a specified length of time. If approval is not granted, the company may recommend alternatives, such as an ambulatory surgical facility. If permission is not obtained and the patient is admitted, the company may refuse to pay or pay at a reduced level.

Many plans require a second opinion prior to certain surgical procedures. Some plans provide the names of up to three surgeons from whom you must obtain another opinion. The cost is usually fully covered, as is a third opinion if you feel it is necessary, when there is some disagreement. If you decide to have surgery, your plan may still require that you follow the hospital predetermination rules before you are admitted to a hospital. If you and your spouse have coverage through two different plans, it is critical that you follow the correct procedures for both plans or the secondary payer may refuse to pay full benefits under the coordination of benefits concept. Contact your employee benefits specialist or insurance company for the details on your plan.

Plan Design Options

- ✓ **Encouraging the Use of Health Promotion and Prevention (Physical Fitness, Smoking Cessation, etc.)**
- ✓ **Requiring Second Surgical Opinion for Certain Procedures**
- ✓ **Increasing Co-Payments and Deductibles**
- ✓ **Encouraging Outpatient Services (e.g., Ambulatory Surgery)**
- ✓ **Encouraging Preadmission Testing**
- ✓ **Adding Home Health Care and Hospice Care**

Source: *What Employers Should Know About PPOs*

Clearinghouse on Business Coalitions for Health Action



Making Sen\$e of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



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V. SENIOR CITIZENS AND HEALTH CARE COVERAGE

This section is designed to assist those consumers 65 years and older in selecting health care coverage to supplement Medicare.

CONSUMER OBJECTIVES:

After completion of this section of leader training, participants should be able to:

1. Identify at least three gaps in Medicare's coverage.
2. List three factors to use when selecting a Medicare Supplement (Medigap) policy.
3. Cite two examples of alternatives to a Medigap policy.
4. List three special "tips" for seniors to keep in mind when shopping for coverage.

Prepared by Lindell C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service
The Ohio State University, 6/86.

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LEADER TEACHING GUIDE

V.

SENIOR CITIZENS AND HEALTH CARE COVERAGE

A. MEDICARE - WHAT IS COVERED AND WHERE ARE THE GAPS?

Lesson Outline

Medicare provides specific benefits through two separate programs:

- Part A - Compulsary Hospitalization Insurance (HI)
- Part B - Voluntary Supplemental Medical Insurance (SMI)

Persons eligible for Part A have the premium provided free; Part B requires a monthly premium.

I. Part A - Hospital Insurance

A. Cover inpatient care in four areas

1. In a hospital
2. Inpatient care in a skilled nursing facility
3. Home health care services after a hospital stay
4. Hospice care

B. Requires Deductible (\$520 in 1987)

1. After 60 days in hospital, patient must also pay \$130/day co-payment
2. After 90 days, a patient may use 60 "once in a lifetime" days with a \$260/day co-payment

II. Part B - Medical Insurance

A. Covers:

1. Doctors' services (except routine physicals)
2. Outpatient hospital Services

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Call or visit the local Social Security Office to obtain a copy of "Your Medicare Handbook." Since this information is somewhat technical, thoroughly review the handbook prior to the presentation. Additional free copies are available from local Social Security Offices (in Greater Cleveland - call 476-1414).

Display and discuss Exhibit V-A - "The Medicare Program Part A - What It Pays... What You Pay."

Display and discuss Exhibit V-B - "The Medicare Program Part B - What It Pays... What You Pay."

For more information, refer to "Medicare Handbook for the Consumer" by the National Consumers League.

815 15th Street NW
Suite 516
Washington, DC 20005

3. Laboratory services
4. X-ray and radiation therapy
5. Unlimited home health visits
6. Physical therapy and speech pathology services
7. Durable medical equipment
8. Limited ambulance services
9. Prosthetic devices and other medical supplies and equipment

For more information on home health care, review "Home Health Care" factsheet (contains guidelines for selecting providers).

B. Requires deductible (\$75 in 1987)

C. Co-insurance pays 80% of Medicare approved amount

D. "Accepting Assignment" - when doctor agrees to accept the Medicare-approved fee as the whole fee

Using Exhibit V-C, work out the two examples to demonstrate assignment concept.

1. Provider files claim; receives payment directly
2. Patient pays other 20% (after \$75 annual deductible is met)

E. "Nonassignment" - doctor does not accept Medicare-approved fee

Refer to "How To Fill Out A Medicare Claim Form." Review steps with class. Additional free copies available from local Social Security offices.

1. Patient must file medical insurance claim (Medicare payment sent to patient).
2. Medicare pays 80% of "reasonable charge" for covered services (after \$75 annual deductible is met)
3. Patient must pay other 20% of approved charge plus any amount over approved fee charged by provider.

Medicare does not pay all costs associated with health care. According to the American Association of Retired Persons (AARP), Medicare only pays an average of about 40% of health care bills; 30% is paid directly by Medicare recipients.

The three major categories of expenses not covered by Medicare that represent gaps are:

I. Medicare deductibles and co-payments for covered services

II. Medical items and services that Medicare does not cover at all

A. This area involves the largest out-of-pocket costs to Medicare beneficiaries

B. Few private health insurance policies offer significant additional protection here

C. Major gaps in hospital insurance

1. Services after 150 days of hospitalization (90 if reserve days are used up)

2. Services after 100 days of skilled nursing care

3. Nursing home care other than a skilled nursing facility

4. A private room or private duty nursing

D. Major gaps in medical insurance:

1. Drugs and medicines (while not hospitalized)

2. Eyeglasses and routine eye exams

3. Hearing aids and routine hearing loss exams

4. Dental care

5. Services not medically necessary or received in a foreign country.

Review "Bridging the Gaps in Medicare."

Display and discuss Exhibit V-D - "Medicare Does Not Cover: Deductible and Co-payments."

Display and discuss Exhibit V-E - "Medicare Does Not Cover: Non-covered Items and Services."

E. Any care deemed primarily "custodial."

1. Care for personal needs (e.g. bathing, eating)
2. Provided by persons without professional skills and training.

Review definition of "Custodial Care" with class. Ask for examples of this type of care.

III. Charges that exceed "Reasonable Charges"

- A. Inpatient hospital care reviewed by Professional Review Organization (PRO) and determined to be medically unnecessary
- B. Doctor's care in excess of what is considered usual medical practice in that area
- C. Services or supplies not generally accepted as reasonable or necessary
- D. Most private health insurance supplemental policies do not cover these charges
- E. Whenever possible, seek providers who supply services or supplies on an assignment basis

Display and discuss Exhibit V-F - "Medicare Does Not Cover: Costs Exceeding What Are Considered 'Reasonable and Necessary Charges.'"

If the patient feels that a Medicare claim has been incorrectly denied, they may appeal the decision. Only 2-3% of Medicare beneficiaries ever appeal, but 50% of appealed claims are decided in favor of the beneficiaries.

Read "Your Right To Appeal Decisions on Hospital Insurance Claims" and "Your Right To Appeal Your Medical Insurance Payment." Review with class.

EXHIBIT V-A

THE MEDICARE PROGRAM PART A - What It Pays... What You Pay...

HOSPITAL INSURANCE (PART A) COVERS:

- INPATIENT HOSPITAL CARE
- POST-HOSPITAL SKILLED NURSING FACILITY CARE
- POST-HOSPITAL HOME HEALTH CARE
- HOSPICE CARE

MEDICARE SERVICES	BENEFIT PERIOD	MEDICARE PAYS	YOU PAY
PART A: HOSPITAL INSURANCE Semi-private room rate Miscellaneous hospital services and supplies Dietary and meal services Special care units Diagnostic procedures, x-rays, etc. Laboratory services Operating and recovery rooms Anesthesia Rehabilitation services	First 60 Days	All but deductible	Deductible \$520
	61st to 90th Day	All but \$130 per day	\$130 per day
	90th to 150th Day	All but \$260 per day	\$260 per day
	Beyond 150 Days	NOTHING	ALL COSTS
SKILLED NURSING CARE In approved facility after 3-day hospital stay and enter the facility within 30 days of discharge	First 20 Days	All Costs	Nothing
	21st to 100th Day	All but \$65.00	\$65.00 per day
	Beyond 100 Days	NOTHING	ALL COSTS
Home Health Care	Unlimited as medically necessary	ALL COSTS	NOTHING
Hospice	Two 90-day periods and one 30-day period	All costs but outpatient drugs and respite care	Limited drug costs and respite care
Blood	As needed	All but first 3 pints	First 3 pints

EXHIBIT V-B

THE MEDICARE PROGRAM
PART B -
What It Pays...
What you Pay...

MEDICAL INSURANCE (PART B) COVERS:

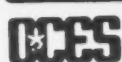
- DOCTORS' SERVICES
- OUTPATIENT HOSPITAL SERVICES
- HOME HEALTH CARE (WITHOUT A HOSPITAL STAY)
- OTHER HEALTH CARE SERVICES: LAB SERVICES;
X-RAY; MEDICAL EQUIPMENT; LIMITED AMBULANCE;
PROSTHETIC DEVICES

MEDICARE SERVICES	BENEFIT PERIOD	MEDICARE PAYS	YOU PAY
PART B: PHYSICIAN INSURANCE Physician and surgeon fees Physical/speech therapists Diagnostic tests Medical supplies Inpatient and Outpatient services Ambulance service	As medically necessary	80% of approved amount after \$75 deductible	\$75 deductible & 20% of balance (you also pay any charge above approved amount)
Home Health Care	Unlimited as medically necessary	ALL COSTS	NOTHING
Outpatient Hospital Treatment	Unlimited as medically necessary	80% of approved amount after \$75 deductible	After deductible 20% of balance
Blood	As needed	80% of approved amount after 3 pints	First 3 pints and 20% of balance



Making Sense of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE



OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



HOME HEALTH CARE

Home health care consists of a wide variety of services provided to older, disabled, and/or convalescent persons who do not need institutional care but require some assistance in meeting their health care needs. Skilled care is given under the general direction of a doctor and consists of health services provided by licensed professionals, such as registered nurses and physical therapists. Supportive services are those provided in addition to skilled care which enable a person to continue independent living at home. These include assistance with personal needs, such as bathing and dressing and household chore services, such as shopping and meal preparation.

Medicare, Medicaid, and private insurance (i.e., insurance companies, Blue Cross/Blue Shield, HMO's) may cover some of the costs of home health care. Medicare coverage of home care is restricted to homebound persons who require "intermittent" skilled nursing care or physical or speech therapy and use a home health agency certified by Medicare. Beyond the minimal services required by federal regulation (skilled nursing on an intermittent basis, home health aides, medical supplies and equipment), each state decides what it will cover under Medicaid.

Coverage by private insurers varies widely, although more and more plans are covering some form of home health care. Policies generally cover nursing care, occupational and physical therapists and home health aides, with limits. Policy provisions, such as deductibles and co-insurance apply.

Other sources of financing for home health care to pursue are health maintenance organizations (HMO's) and area agencies on aging that contain a health service component, such as visiting nurse, immunization, screening programs, and home-delivered meals.

The quality of services varies. Check with knowledgeable people to find out what services are available. Sources of this information include:

- local hospital discharge planners
- local or county public health and welfare departments
- social services departments
- Area Agency on Aging
- United Way (lists nonprofit voluntary agencies)
- telephone directory
- yellow pages under "Home Health Services" or "Nurses"
- churches/synagogues
- day care centers (for seniors)
- medical or surgical centers
- nursing homes
- Social Security Administration
- physicians

The National Consumers League recommends the following:

CHECKLIST FOR CONSUMERS OF HOME HEALTH CARE

The following questions should help a potential user of home health services to evaluate agency programs.

Standards

1. Is the agency licensed by the state? Have any complaints against the agency been filed with the state regulating agency (generally the state health department)?
2. Is the agency accredited by one of the following:
 - a) National League for Nursing/American Public Health Association
 - b) National HomeCaring Council
 - c) Joint Commission on Accreditation of Hospitals
3. Is the agency and its employees bonded?
4. Is the agency Medicare/Medicaid-certified?
5. How long has the agency been operating in the community? Can the agency provide you with references?

Services

1. Does the agency provide a complete list of its services?
2. Does the agency confer with your doctor before providing services? How does the agency coordinate with the doctor on the plan of care and monitor to see that the plan is being followed?
3. Is care available on the weekends or after regular hours?
4. What procedures does the agency use in an emergency?

Costs

1. Does the agency provide a written list of services and the cost for each service? Does it explain which services are covered by your private insurance, Medicare, Medicaid or other sources of financial assistance and which services you will be responsible for paying?
2. Do you sign a service agreement or a contract allowing the agency to bill your insurance company or Medicare or agreeing to cover the costs yourself? What if you are dissatisfied with the service?

3. How are the costs billed--per visit, per hour or on some other basis? Are there minimum hours or days per week required? Do you sign a time sheet for each employee? Are you billed each week for the services you received that week?

4. If fees are on the basis of hourly or per visit charges, are all services covered? Are there separate charges for an evaluation visit; employee social security or travel?

5. If you have private or government insurance, will the agency handle the billing to them? If you have to pay for some or all the services, what arrangements can you make for payment?

Agency Personnel

1. Do the people whom the agency refers to you work for the agency or do you become their employer?

2. Could you be liable for an injury or accident to an agency employee in your home?

3. What kind of education, training, and experience do the agency personnel have? Have they met state licensing requirements for their profession, and are they certified by their professional organizations?

4. Are references required of the agency personnel prior to hiring? Have their references been checked? Can you see them?

5. Will you be assigned the same person for the length of time you need care? Does the agency check with you to see if the people assigned to you are satisfactory? What happens if you complain about a person assigned from the agency? Will you get a replacement and, if so, how quickly?

6. Does the agency have a full range of health service personnel on staff or does it sub-contract? How does it ensure the reliability and competence of these personnel?

7. What supervision does the agency provide for the people it sends to your home? Does a supervisor come out to observe the employee, to check on how he or she is carrying out your plan of care and to find out if you are satisfied?

8. Does the agency provide registered nurses, licensed nurses, or both? How much education, training, and experience are they required to have? Does the agency have its own testing system for its staff and requirements for in-service training?

9. Does the agency require home health aides to be licensed or certified? How much training and/or experience are they required to have?

SOURCE: Home Health Care. National Consumers League, 815 15th Street NW, Suite 516, Washington, DC 20005. Reprinted with permission.

EXHIBIT V-C

EXAMPLES OF ASSIGNMENT
CONCEPT

DOCTOR ACCEPTS ASSIGNMENT

(Yearly deductible not met)

Fee	\$ 600
Medicare approved	475

You must pay:

Deductible	75
20% of approved charge, less deductible	80

TOTAL COST TO PATIENT -----	\$ 155
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DOCTOR DOES NOT ACCEPT ASSIGNMENT

Fee	\$ 600
Medicare approved	475

Difference patient must pay	\$ 125
-----------------------------------	--------

Total Cost To Patient

Difference	\$ 125
Deductible	75

20% of \$400	80
--------------------	----

\$ 280

need, and an estimate of how long the equipment will be medically necessary.

CLAIMS FOR A PERSON WHO DIED

There are special rules for submitting claims for a deceased Medicare beneficiary. Any Social Security office or your Medicare carrier can give you information about these special rules.

KEEP A RECORD OF YOUR CLAIM

It's a good idea for you to keep a record of your claim in case there is ever any need to inquire about it. Before you send in a Form 1490-S, you should write down the date you mail it, a description of the services or supplies you received, the date and charge for each service or supply, and the name of the doctor or supplier who provided the services or supplies.

WHERE TO SEND YOUR CLAIM

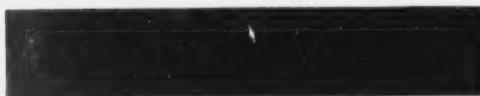
Send the Form 1490-S and itemized bills to your Medicare carrier. If the carrier's name and address are not shown in the upper right-hand block of the form, you can find the name and address in *Your Medicare Handbook*. Or, you can call any Social Security office to get the carrier's name and address.



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

Publication No. HCFA 10083
July 1984

How to Fill Out A Medicare Claim Form



July, 1984



WHEN TO USE THE PATIENT'S REQUEST FOR MEDICARE PAYMENT (Form 1490-S)

The *Patient's Request for Medicare Payment* (also called Form 1490-S) is shown on the next page. This is the form to use when *you* are requesting payment from Medicare. You can get this form from any Social Security office or your Medicare carrier (the names and addresses of all Medicare carriers and the areas they serve are shown in the back of *Your Medicare Handbook*). When you submit a claim, the carrier will send you another form for your next claim.

Before using this form, make sure your doctor or supplier is not submitting a claim on your behalf. If your doctor is sending a claim to Medicare for you, you should *not* use Form 1490-S. Also, if you haven't done so already, ask your doctor if he or she will accept Medicare *assignment*. Medicare's assignment method of payment can save you the trouble of filling out a claim form...and it can save you money as well. *Your Medicare Handbook* describes the assignment method of payment in detail.*

**Physician/Supplier Assignment Rate Lists*, showing the approximate percentage of claims on which physicians and suppliers in your area accepted assignment in the previous calendar year, are now available for review in all local Social Security offices and all State and Area Agencies on Aging.



MEDICARE CLAIM FORM (1490-S)

Print your health insurance number exactly as it's shown on your Medicare card. Be sure to include any letter either at the beginning or the end of the number.

Print your complete address — street, city, State, and ZIP code.

Briefly describe the condition (illness or injury) for which you were treated. If you were treated for different conditions, describe each.

Check the box marked "yes" or "no."

If you have private health insurance or are covered under a State medical assistance program (such as Medicaid), print the name and address of the insurance company or State program.

Sign your name. (Do not print.)

This example form is a 68% reduction of the original 8 1/2" x 11" form.

Form Approved
OMB No. 09-R0012

PATIENT'S REQUEST FOR MEDICARE PAYMENT

IMPORTANT— SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

1 Name of Beneficiary From Health Insurance Card (First) (Middle) (Last)		SEND COMPLETED FORM TO:	
2 Claim Number From Health Insurance Card 		☐ Male ☐ Female	
3 Patient's Mailing Address (City, State, Zip Code) Check here if this is a new address ☐		3b Telephone Number (Include Area Code)	
(Street or P.O. Box—Include Apartment number) _____ (City) (State) (Zip)		4 Describe The Illness or Injury for Which Patient Received Treatment _____ _____ _____	
4b Was illness or injury connected with employment? ☐ Yes ☐ No		5 If any medical expenses will be or could be paid by your private insurance organization, State Agency, (Medicaid), or the VA complete block 5 below. Name and Address of other insurance, State Agency (Medicaid), or VA office _____ _____ Policy or Medical Assistance Number _____	
NOTE: If you DO NOT want payment information on this claim released put an (x) here ☐			
I authorize Any Holder of Medical or Other Information About Me to Release to the Social Security Administration and Health Care Financing Administration or Its Intermediaries or Carriers any Information Needed for This or a Related Medicare Claim. I Permit a copy of this Authorization to be Used in Place of the Original, and Request Payment of Medical Insurance Benefits to Me.			
6 Signature of Patient (If patient is unable to sign, see Block 6 on other side.) _____		6b Date Signed _____	

IMPORTANT!

ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM.

HCFA-1490B (5-80) Department of Health and Human Services—Health Care Financing Administration

Print your name exactly as it's shown on your Medicare card.

If the carrier's name and address are not shown here, the names and addresses of all Medicare carriers, and the areas they serve, are shown in the back of *Your Medicare Handbook*.

Check the box next to male or female.

Print the telephone number where you can be reached.

Print your private insurance policy number or State medical assistance number.

Put an X in this box only if you do not want information about this Medicare claim given to your private insurance company or State medical assistance program.

Print the date you signed this form.

You must attach itemized bills. See page 5 for a list of what must be included on an itemized bill.

HOW TO COMPLETE FORM 1490-S

If your doctor or supplier does not accept assignment, you must send in the claim to receive payment. You fill in the form as shown in the diagram and attach itemized bills for the services you received. The information that must be shown on itemized bills is shown below.

It is important that the form be completed properly. Incomplete or incorrect information on the form may delay payment.

You should keep this leaflet handy so that you can refer to it whenever you have to fill out a Form 1490-S.

If you ever need assistance in completing the form, contact any Social Security office or your Medicare carrier. The people there will be glad to help you and can answer any questions you have about Medicare.

AN ITEMIZED BILL

The itemized bills you send in with your Form 1490-S must contain specific information or your claim may be delayed. A bill which simply says "For professional services rendered" or "Balance forward" is not an itemized bill.

If the doctor or supplier gives you an itemized bill that does not show all of the following information, ask him or her to fill in what is missing. Each itemized bill you submit must show *all* of the following information:

- A complete description of each service or supply you received.

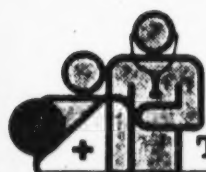
- The date you received each service or supply.
- The place where you received each service or supply.
- The charge for each service or supply.
- The name of the doctor or supplier who provided each service or supply. (If more than one doctor's name is shown on the bill, please circle the name of the doctor who treated you.)
- Your name and your complete health insurance number *exactly* as they are shown on your Medicare card. (If the doctor or supplier does not put your name and number on the bill, you can write them on it.)
- It is helpful, but not necessary, if the diagnosis is shown on the bill.

You can send in more than one itemized bill with a single Form 1490-S. It doesn't matter whether all the bills are from one doctor or supplier or from different doctors or suppliers. And, you can send in the bills either before or after you pay them.

CLAIMS FOR DURABLE MEDICAL EQUIPMENT

If you rent or purchase durable medical equipment, such as a wheelchair or oxygen equipment, and are submitting form 1490-S, you must include the bill from the supplier who provided the equipment and a doctor's prescription. The prescription must show the equipment you need, the medical reason for your





Making Sense of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE

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SECTION V-A

BRIDGING THE GAPS IN MEDICARE

Medicare is not an all-inclusive health insurance program. According to the American Association of Retired Persons (AARP), Medicare pays an average of about 40% of health care costs while 30% is paid directly by Medicare recipients. If you're hospitalized, you'll be charged a \$520 (in 1987) deductible. After that, Medicare's Part A pays for 60 days in a semi-private room, plus lab work, operating rooms, drugs, x-rays, rehabilitation and other services. From the 61st to the 90th day you'd be responsible for co-payments of \$130 a day. After that you'd start using "reserve days," and paying co-payments of \$260 a day. Each Medicare beneficiary has a lifetime total of 60 reserve days. When they're exhausted, Medicare pays nothing.

The program doesn't pay for custodial care, but under certain conditions it will pay for care in a skilled nursing facility or home health care visits. The deductible must be paid every time you're admitted to a hospital, unless the "benefit period" hasn't expired. A benefit period starts when you are admitted to a hospital and ends 60 days after you leave the hospital or a nursing home.

There is also a \$75 (1987) deductible for Part B, which helps pay for doctors and certain other services. Medicare then pays 80% of what it considers reasonable charges, or the "Medicare approved" amount. You pay the rest, plus any amount not judged to be reasonable unless your provider accepts assignment. The 80% co-insurance applies to the other services covered by Part B (outpatient hospital care, outpatient physical therapy, speech pathology, and home health care). The monthly premium for Part B in 1987 is \$17.90, which is subtracted from the monthly Social Security check.

Medicare pays nothing for prescription drugs, eyeglasses or hearing aids, for private-duty nurses or most immunizations; for routine physical exams, dental or foot care; for eye and hearing exams; or for medical care in a foreign country.

Prepared by Linda C. Northup, Program Assistant, as part of a Research and Training project of the Cuyahoga County Cooperative Extension Service.
The Ohio State University, 6/86.

All educational programs and activities conducted by the Ohio Cooperative Extension Service are available to all potential clientele on a non-discriminatory basis without regard to race, color, national origin, sex, handicap or religious affiliation.

Issued in furtherance of Cooperative Extension work, Acts of May 8 and June 30, 1914, in cooperation with the U.S. Department of Agriculture, J. Michael Sprott, Director of Ohio Cooperative Extension Service, The Ohio State University.

The three major categories of health care expenses (gaps) not covered by Medicare are:

- The Medicare deductibles and co-payments for services Medicare covers.
- The medical items and services Medicare does not cover at all.
- The difference between the "reasonable charge" approved by Medicare and the actual charge for covered services by doctors and suppliers.

Your choice of additional health care coverage, if you decide you want and need added protection, should be based on a careful consideration of how well it fills the gaps in Medicare that you feel you should be insured against.

The Health Action Council of Northeast Ohio recommends these ten TIPS on controlling health care costs for Medicare recipients:

- Seek out participating physicians who accept assignment. (Acceptance of Medicare-approved fee as the whole fee.)
- If you see a non-participating physician, be aware that he or she can still accept assignment and encourage this.
- Check your bills for possible errors.
- Ask for a second opinion if surgery is recommended.
- Take no more drugs than are absolutely necessary.
- Consider generic drugs - they are always less expensive.
- Consider out-patient surgery.
- Avoid entering the hospital on a weekend for a procedure that is not going to take place until the following week.
- Be aware of alternatives to institutionalized care: day care, Meals on Wheels, home health, hospice, life care communities, etc.
- Stay healthy. Healthy lifestyles and preventive measures could reduce the cost of health care.

For more information, refer to The Prudent Patient by the American Association of Retired Persons (AARP), 1909 K Street, N.W., Washington, D.C. 20049.

EXHIBIT V-D

**MEDICARE DOES NOT COVER:
DEDUCTIBLES AND CO-PAYMENTS**

(1987 Amounts)

HOSPITAL INSURANCE

- \$520 FOR THE FIRST 60 DAYS OF INPATIENT HOSPITAL SERVICES IN A BENEFIT PERIOD (THE INPATIENT HOSPITAL DEDUCTIBLE).
- \$130 A DAY FOR THE 61st THROUGH 90th DAY OF INPATIENT HOSPITAL SERVICES IN A BENEFIT PERIOD.
- \$260 A DAY FOR EACH "LIFETIME RESERVE" DAY USED.
- \$65 A DAY FOR THE 21st THROUGH 100th DAY IN A BENEFIT PERIOD FOR INPATIENT CARE IN A SKILLED NURSING FACILITY.
- THE FIRST 3 PINTS OF BLOOD IN A BENEFIT PERIOD.

MEDICAL INSURANCE

- THE FIRST \$75 EACH YEAR OF "REASONABLE CHARGES" FOR COVERED SERVICES (THE ANNUAL MEDICAL INSURANCE DEDUCTIBLE).
- 20 PERCENT OF THE "REASONABLE CHARGES" FOR ALL COVERED SERVICES ABOVE THE DEDUCTIBLE.
- THE FIRST 3 PINTS OF BLOOD IN A CALENDAR YEAR.

EXHIBIT V-E

MEDICARE DOES NOT COVER:
NON-COVERED ITEMS AND
SERVICES

HOSPITAL INSURANCE (Part A)

- MORE THAN 150 DAYS OF INPATIENT HOSPITAL CARE IN A BENEFIT PERIOD (OVER 90 DAYS IF YOU HAVE USED ALL YOUR "LIFETIME RESERVE" DAYS).
- MORE THAN 100 DAYS OF INPATIENT SKILLED NURSING FACILITY CARE IN A BENEFIT PERIOD.
- NURSING HOME CARE IN OTHER THAN A SKILLED NURSING FACILITY.
- PRIVATE DUTY NURSING.
- PRIVATE ROOM (UNLESS MEDICALLY NECESSARY).

MEDICAL INSURANCE (Part B)

- DRUGS AND MEDICINES YOU BUY YOURSELF.
- EYEGLASSES (EXCEPT AFTER CATARACT SURGERY).
- HEARING AIDS.
- DENTAL CARE.
- * * * * *
- MOST CARE RECEIVED OUTSIDE THE UNITED STATES.
- SERVICES AND SUPPLIES THAT ARE NOT MEDICALLY NECESSARY.
- CUSTODIAL CARE

EXHIBIT V-F

**MEDICARE DOES NOT COVER:
COSTS EXCEEDING WHAT ARE
CONSIDERED "REASONABLE
AND NECESSARY CHARGES"**

- INPATIENT HOSPITAL CARE REVIEWED BY PEER REVIEW ORGANIZATION (PRO) AND DETERMINED TO BE MEDICALLY UNNECESSARY.
- DOCTOR'S CARE IN EXCESS OF WHAT IS CONSIDERED USUAL MEDICAL PRACTICE IN THAT AREA.
- SERVICES AND SUPPLIES NOT GENERALLY ACCEPTED AS REASONABLE OR NECESSARY.

The hearing is conducted by a hearing officer appointed by the carrier. The hearing officer will not have been involved in the previous decisions made on your claim. He or she will review what has already happened in the case, state what must be decided, and ask questions of you and any witnesses present. The hearing officer may ask a witness for the carrier to attend the hearing to explain how the carrier arrived at its decision. You and your representative may question the witnesses, present new evidence, and examine the evidence on which the hearing officer will base his or her decision.

You do not have to appear at the hearing. If you don't, the hearing officer will base his or her decision on the written evidence which was previously submitted in the case plus any additional written evidence or statements.

A copy of the hearing officer's decision will be sent to you. The decision of the hearing officer is final. The law does not provide for further review of medical insurance claims.

YOUR RIGHT TO BE REPRESENTED

You have a right to be represented at any stage of your claim for medical insurance payment. Your representative may be an attorney, a relative, or any other qualified person you choose. You are responsible for paying any fee your representative may require.

FOR MORE INFORMATION

If you have any questions about your right to appeal a decision on your medical insurance claim, call any Social Security office or your Medicare carrier. The people there will be glad to help you.

Your Right To Your Medical Insurance Pay

Your Right To Appeal Your Medical Insurance Payment



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Health Care Financing Administration

May 1984



Publication No. HCFA 10079
May 1984



May 1984



YOUR RIGHT TO APPEAL YOUR MEDICAL INSURANCE PAYMENT

Claims for payment under the medical insurance part of Medicare are handled by Medicare carriers. The carrier is an insurance organization under contract with the Federal Government.

When a claim is submitted, the carrier first examines it to determine if the services are covered by medical insurance. Then the carrier determines the "approved" charges for such services. For an explanation of how "approved" charges are figured, please read the chapter on "Approved charges" in *Your Medicare Handbook*. If you don't have a handbook, you can get one from any Social Security office.

If the carrier decides that some or all of the services are not covered or that the charge for the services is more than the approved amount, it may either deny the claim or make payment on the basis of the approved charge. The carrier will notify you of its decision and the reasons for the decision.

If you disagree with the carrier's decision to disallow all or part of your claim, you can appeal the decision. This leaflet describes the steps you may take. **These steps apply only to medical insurance claims.** Different rules apply to Medicare hospital insurance claims. You can get a copy of the leaflet *Your right to appeal decisions on hospital insurance claims* at any Social Security office.



AN IMPORTANT NOTE

The carrier is required by law to make an initial decision on medical insurance claims with reasonable promptness. If it does not take action within 60 days from the time you file your claim, you may request a hearing. Your request may be made directly to the carrier or through a Social Security office.

STEP 1: Request a review

If you disagree with the decision on your claim, you may ask the carrier to review it.

A request for review must be made within 6 months of the date of the notice of the initial decision.

The request must be in writing. It should show your name and health insurance claim number and the reasons you disagree with the decision. It also should include any claim number and/or control number which was shown on the notice of decision or *Explanation of Medicare Benefits* sent to you by the carrier. If you have additional evidence to support your claim, you should submit it with your request.

You may send your request either to the carrier that handled your claim or to a Social Security office, which will forward it to the carrier.

The carrier will examine all the evidence to determine if the original decision was correct. This review is not made by the person who made the original decision, but by another qualified person.



You do not personally appear before the carrier. The review is based only on the written documents in file.

A notice of the review decision will be mailed to you.

STEP 2: Request a hearing

If you still disagree with the decision on your claim after it has been reviewed, you may request a hearing. You will be entitled to a hearing **only** if the difference between Medicare's approved charge (minus any deductible and coinsurance) and the actual bill for services is at least \$100. To meet the \$100 minimum, you can count other claims that you have had reviewed within the past 6 months.

A request for a hearing must be filed within 6 months of the date of the notice of the review decision. You can send the request to the carrier that handled your claim or to a Social Security office for forwarding to the carrier.

The request must be in writing. It should show your name and health insurance claim number and give the reasons you disagree with the review decision. Be sure to also include any claim number which was shown on the notice of review decision. You may submit any additional evidence that you want to have considered.

You will be notified of the place, date, and time of the hearing. You may appear personally at the hearing, and you may have someone represent you if you choose.



LEADER TEACHING GUIDE

V. SENIOR CITIZENS AND HEALTH CARE COVERAGE

B. OPTIONS FOR SUPPLEMENTING MEDICARE

Lesson Outline

If you or your spouse are approaching age 65 and are eligible for Medicare and are covered by a group health plan which covers at least 20 workers and plan to continue working, you can choose to:

- I. Remain on your employer's plan and receive the same coverage as other employees which Medicare will supplement,* or
- II. Select Medicare as the primary insurer with the employer's plan supplementing.

If you or your spouse are approaching age 65 and are planning to retire, you should begin to consider your options for supplementing your Medicare coverage. These include:

- I. Continuation or conversion of pre-65 coverage
 - A. May be similar or take form of a Medicare supplement policy - premium may be changed
 - B. No pre-existing condition exclusions
 - C. No medical data required
 - D. No waiting periods
 - E. Employer may pay part or all of premium

* Employed persons on company health care plans who continue to work past 65 and who stay on the company plan may elect not to take Medicare Part B (for which they must pay \$17.90 a month) with no penalty or wait for yearly enrollment period once they decide to retire.

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Review "Employed Medicare Beneficiaries Age 65 Through 69" prior to presentation.

Display Exhibit V-G, "Options In Health Care Coverage For Working Persons Ages 65 and over; briefly describe each option.

Display Exhibit V-H, "Options In Health Care Coverage, Retired Persons 65 and Over To Supplement Medicare"; briefly discuss each option. Ask participants to describe their own forms of coverage.

II. Major Medical Insurance

- A. Can sometimes be converted from a group policy
- B. Difficult for individuals over 65 to buy
- C. Large deductible (\$500-\$1,000)
- D. May or may not cover Medicare's deductibles and co-insurance

III. Medicare Supplement (Medigap) Policies

- A. Usually covers only services also covered by Medicare
- B. Usually pay some or all of deductibles and co-payments Medicare does not pay
- C. Best policies cover deductibles and co-payment for both Part A & Part B and additional days of inpatient hospital and skilled nursing facility care

IV. Health Maintenance Organizations (HMOs)

- A. Pay a membership fee
- B. HMO furnishes all services
- C. Membership fee covers Medicare deductibles and co-insurance
- D. Services are pre-paid, no claims forms to process

Review "More Health For Your Dollar: An Older Person's Guide To HMOs." Additional copies available from:

AARP
1909 K Street, N.W.
Washington, D.C. 20049

Read "Medicare and Prepayment Plans." Additional free copies available from local Social Security offices.

V. Hospital - Indemnity Policies

- A. Per-day cash payments
- B. Only pay for actual days in hospital
- C. Often do not begin on first day of hospitalization
- D. Often have maximum number of days or maximum payment
- E. Payments do not increase with inflation
- F. May have pre-existing condition exclusions

VI. Limited Coverage Policies

- A. Intensive Care
- B. Accident
- C. Skilled Nursing Home
 - 1. Usually pays per-day amounts
 - 2. Does not pay for custodial care
- D. Specified Disease (e.g., cancer)
 - 1. Covers single disease
 - 2. Often have restrictive conditions

EXHIBIT V-G

OPTIONS IN HEALTH CARE COVERAGE

WORKING PERSONS

AGES 65 AND OVER

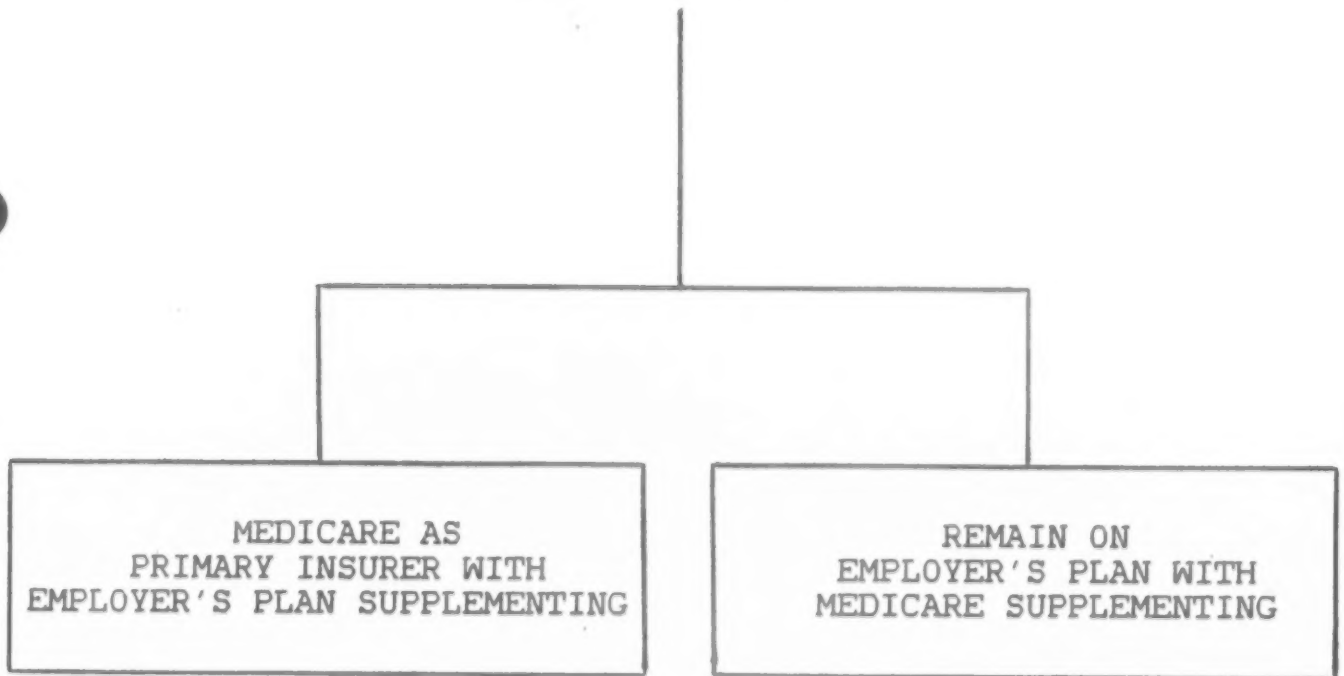
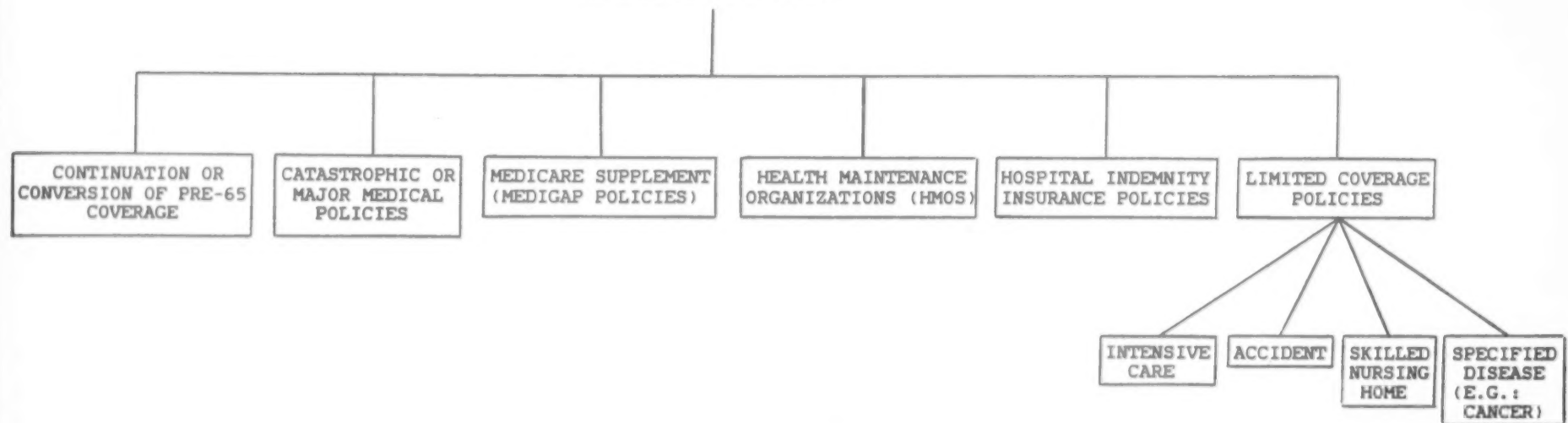


EXHIBIT V-H

OPTIONS IN HEALTH CARE COVERAGE

RETIRED PERSONS 65 AND OVER
TO SUPPLEMENT MEDICARE





MORE HEALTH FOR YOUR DOLLAR

AN
OLDER
PERSON'S
GUIDE
TO
HMOs



January 1986

Dear Consumer:

Today's health marketplace has exploded with choices for health care. Consumers of all ages are being challenged to find the right health care at an affordable price.

AARP believes that health maintenance organizations (HMOs) are an option that deserves your attention. We recognize that HMOs function differently from the health care system most of us know. Of course an HMO has doctors, nurses, and lab technicians working in medical offices, and people who join an HMO go to the hospital as necessary. The difference is that an HMO combines health care *and* health insurance. And when you join an HMO you are agreeing to use the health professionals and facilities that are part of the HMO.

HMOs are important for many older Americans because they provide quality health care at a fixed, reasonable price. Many HMOs charge a fee that is lower than the premium currently charged for Medicare supplemental insurance policies. Frequently, the benefits and services provided by an HMO are more extensive than those covered by regular Medicare plus a supplemental policy. Members of an HMO don't have the hassles of filing Medicare claim

forms, and of searching for a physician who accepts Medicare assignment.

As part of AARP's campaign to reform our health care system, we are urging consumers to find out about HMOs. To help consumers learn more about HMOs AARP, with funding from the Health Care Financing Administration, has a pilot project in five major cities that provides consumer education and price information about HMOs. The volunteers in this "HMO Informed Buyer Project" are presenting consumer education forums to explain the pros and cons of health maintenance organizations, and are helping consumers decide whether HMO membership is right for them.

Changing the way we receive health care is an important decision, and should be based on your needs, current health costs, and personal values. We hope you'll use this booklet when deciding whether an HMO is the right health option for you. It could be the decision that helps you "Cut the Cost/Keep the Care."

Sincerely,



Cyril F. Brickfield
Executive Director



MORE HEALTH FOR YOUR DOLLAR

AN
OLDER
PERSON'S
GUIDE
TO
HMOs

Contents

Acknowledgement

This guide to health maintenance organizations was written by Boston University's Health Policy Institute. AARP commends the authors for their work, and is grateful to the organizations and individuals who provided comments and suggestions on the manuscript.

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American Association of Retired Persons
1909 K Street NW, Washington, DC 20049

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Introduction

Anyone who's visited the doctor or been in the hospital recently knows that medical care is expensive. Older people particularly feel the pinch of these rising costs. Out of pocket health expenses for older consumers average \$1,600 annually, while costs for younger people will average about \$800.

Medicare helps pay for much of your health care, through Part A (Hospital Insurance) and Part B (Medical Insurance), but if you have used Medicare recently, you know it just doesn't pay all the bills. Medicare falls short due to:

- Deductibles—amount you must pay before Medicare begins to pay,
- Co-Payments—amounts you pay as part of the Medicare benefits,
- Special restrictions and exclusions—services not covered by Medicare.

And, despite the fact that you're paying more and more for your medical bills, Medicare does not cover important services such as preventive check-ups, eye examinations, and routine dental care.

Is there a way to get these services at a lower cost without sacrificing quality care?

For many people, the answer might be "Yes" if you belong to a health maintenance organization (HMO).

HMOs now provide health care to more than 17 million Americans, including more than 1 million Medicare beneficiaries, and that number is growing. Because of recent changes in Medicare regulations regarding HMOs, and because consumers are becoming more aware about the benefits and potential cost savings of HMO membership, you'll probably be hearing a lot more about HMOs in the near future.

We think it's important that older people have all the facts about HMOs. In this booklet, we'll explain:

- what an HMO is;
- how HMOs work in connection with Medicare; and
- what the advantages and disadvantages of joining an HMO are.

We'll also give you some questions to ask yourself and others before making your decision, and a worksheet to compare benefits between the regular Medicare program, your supplemental insurance, and an HMO.

We hope this booklet provides you with the information you need to sort out your HMO options under Medicare, and to assist you in making your decision. While the American Association of Retired Persons does not endorse any particular HMO, we do feel it is an alternative form of health care coverage you should know more about.

What Is a Health Maintenance Organization?

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Health maintenance organizations provide both health insurance and health services through one organization. They combine the functions of helping to pay for and providing health care services into a single program. HMOs offer an alternative to the traditional way doctors deliver care.

An HMO provides a wide range of health care services through specially designated doctors, hospitals, skilled nursing facilities, home health care agencies and other affiliated health care professionals and facilities.

Generally an HMO will not pay for health services you receive from a provider or facility not affiliated with that HMO. The limited exceptions to this rule are described in the next section.

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Types of HMOs

There are two major types of health maintenance organizations—group practice HMOs and individual practice HMOs.

Group Practice HMOs provide physician services to their members at one or more centrally located health facilities. These centers usually are staffed by both primary care doctors (internists, family practitioners, general practitioners) and doctors who practice as specialists in fields such as eye care, hearing care, arthritis, urology, heart and circulatory disease, surgery and gynecology. HMO members select one of the primary care doctors as their personal physician. At the center the physicians are assisted by other health professionals and technicians. Some, but not all, group practice HMOs make extensive use of specially trained nurse practitioners or physician assistants to handle routine patient visits. This makes more efficient use of the doctors, allowing them to concentrate on more difficult problems.

In addition to primary and specialty medical care, many centers offer laboratory, X-ray, pharmacy, health education and even ambulatory surgery services within a single location.

If you live near the health center of a group practice HMO, or have convenient transportation to it, this type of HMO might be an excellent place for you to get most of the health care you are likely to need.

Individual Practice HMOs (also called Individual Practice Associations or IPAs) provide physician services at the private practice offices of doctors under contract to the HMO and located within the service area. Individual practice HMOs offer more of a chance to find an HMO doctor practicing near your home. Also, since individual practice HMOs often contract with a larger number of doctors, you probably will have a wider choice of physicians than through a group practice HMO. It is, however, unlikely that individual practice HMOs will have as much equipment or have the wide range of services associated with a group practice HMO center.

Both types of HMOs limit their membership to persons living in an area near the doctors and facilities affiliated with the HMO. This area is called the HMO's "service area."

Both types of HMOs use affiliated hospitals and skilled nursing facilities when inpatient care is required. A few of the largest group practice HMOs have their own hospitals.

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Costs

HMO enrollees pay a fixed premium in advance. When medically necessary, the HMO guarantees to provide all the health services specified in the enrollment contract with no large deductibles or co-payments charged to the patient. Consequently, there are little or no large out of pocket expenses associated with HMOs.

Generally, an HMO does not get paid more for providing more health care services. For example, if you have to see a doctor four times rather than once, you will not pay for four office visits. Therefore, the HMO must operate within a specific budget. This gives the HMO a strong incentive to work out arrangements with its health care providers and facilities to deliver health care in an efficient manner. Studies have shown that this method of operation can result in savings to enrollees. Comparisons between total health care costs of people enrolled in HMOs and people with regular health insurance have found that HMO members usually spent less—sometimes much less—for health care. While this does not guarantee that you will save money by enrolling in an HMO, the HMO's responsibility to provide health care to its members within a budget means it will be more accountable to its enrollees for the cost, quality and availability of those services than traditional health delivery systems.

Health Maintenance Organizations and Medicare

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Since HMOs generally offer comprehensive health care at reasonable prices, the Medicare program has been encouraging older Americans to consider seriously the possibility of enrolling in HMOs serving areas where they live. Medicare today has contracts with more than 125 of the 425 HMOs operating in the United States and currently is seeking to expand that number. Some other HMOs, while not under contract to the Medicare program, provide all the services covered under Medicare Part A and Part B through something called a Medicare "wraparound." A "wraparound" is Medicare supplemental coverage for individuals who are already HMO enrollees at the time they become Medicare beneficiaries.

HMOs participate in the Medicare program under many different rules and regulations. The information in this section applies to most HMOs, but exceptions can be found.

Services

Health maintenance organizations with either Medicare contracts or Medicare "wraparound" packages usually provide at least all the benefits covered by Medicare, such as diagnostic and emergency room services, and medical supplies. (Medicare benefits are fully described in "Your Medicare Handbook," available from any Social Security Office.) In the unusual instance where an HMO is unable to include a Medicare benefit in its HMO program—for example, some HMOs may not be able to offer some types of physical therapy—you will continue to be entitled to that benefit and may obtain it elsewhere through the regular Medicare program. **You will not lose coverage for any benefit you are entitled to under Medicare if you choose to enroll in an HMO.** However, if you join an HMO most of your health care will have to be provided through the HMO to take full advantage of your Medicare benefits.

Eligibility

The rules that determine whether you can join an HMO are different for those HMOs that have contracts with the Medicare program and those that only have the "wrap-around" program for Medicare beneficiaries. To find out if the HMO that interests you has a contract with the Medicare program simply ask your local Social Security Office to find out, or ask the HMO.

As a Medicare beneficiary, you are eligible to join an HMO **that contracts with Medicare** if:

- You participate under Part B (Medical Insurance) of Medicare as well as Part A (Hospital Insurance).
- You live in the HMO service area.
- You do not have end-stage kidney (renal) disease.¹
- The HMO is currently enrolling new members.

¹A special note for persons with end-stage kidney (renal) disease.

For technical reasons, the Medicare program is phasing out the ability of HMO's contracting with Medicare to accept new enrollments of persons having end-stage kidney (renal) disease. However, HMOs that already have contracts with Medicare may continue these contracts temporarily, and persons with end-stage kidney disease may be able to join an HMO under these existing contracts. Check with HMOs in your area or with your local Social Security Office for more information.



contracting with Medicare must accept Medicare enrollments during at least a 30-day period each year.)

If more Medicare beneficiaries apply to join the HMO than can be accepted at that time, applicants will be accepted on a "first come, first served" basis, unless the Medicare program agrees to a different policy. In very rare instances, HMOs with special permission from Medicare may have other restrictions on membership eligibility.

Criteria for membership in those HMOs not contracting with Medicare but which offer "wraparound" packages are set by each HMO in accordance with state regulatory laws. To be eligible you probably will need to have joined the HMO **before** you became a Medicare beneficiary and not have let your HMO membership lapse. Check with the HMO for more information.

If you or your spouse are still working, it is possible that you may join an HMO through your employer's health benefits program. The personnel department or your employee union will have more information. Some companies also include HMO membership as part of their health-benefits program for retirees.

Payments

If you enroll in an HMO, you will pay a premium directly to the HMO. As an HMO member you will be charged little or nothing at all when you receive covered doctor, hospital or skilled nursing care through your HMO. While some HMOs require small co-payments for some services, these generally are much less than what you would be required to pay through the regular Medicare program.

As a Medicare beneficiary, the premiums (and required co-payments, if any) you will pay to the HMO are a very small part of the total HMO costs. **The rest of the cost is paid by the Medicare program.** It is important to remember you must continue to pay the Medicare Medical Insurance (Part B) premium each month to be eligible for enrollment in an HMO. Most Medicare beneficiaries have this premium deducted from their monthly Social Security checks. If you are still working and enrolled through your company's employee health benefits plan, your employer covers these costs.

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How To Use Your HMO

Once enrolled in a health maintenance organization, you will receive most of your medical care through it. Most HMOs operate in the following manner:

• Physician Selection

Generally, each HMO member may select one of the physicians affiliated with the HMO to be his or her personal HMO doctor, often referred to as your "primary care physician." If you do not select a personal HMO doctor, one probably will be assigned to you when you make your first appointment. If you are not satisfied with your primary care physician, most HMOs will let you select a different one.

• Services

Your primary care physician will help you make appropriate use of the range of services available through the HMO. When you require medical attention, you will arrange it by contacting your personal HMO doctor's office. Your care will be provided by the physician or one of the qualified assistants affiliated with your doctor. If your primary care physician thinks that you need the services of another doctor, hospital, health care professional or special facility, the doctor's office will make appropriate arrangements for you. Almost always these services will be provided by professionals and/or facilities affiliated with your HMO.

• Emergencies

Most HMOs provide a special telephone number you can call if you need care but are unable to reach your primary care physician. Also, there may be a walk-in clinic where another HMO doctor can see you for urgent problems.

• Enrollees' Payments

Most HMOs require monthly payment of the premium for membership.

• Reimbursement for Services

Except on rare occasions your HMO will not pay for any service you obtain from health practitioners or facilities not affiliated with the HMO. Exceptions to this rule are made in medical emergencies and when problems requiring immediate medical attention arise unexpectedly while you are temporarily away from the HMO's service area (and it would not be reasonable to return). Also, exceptions are made for services received from doctors or facilities not associated with the HMO upon the specific request (referral) of an HMO doctor. You will not be referred to unaffiliated physicians, however, unless the HMO is unable to provide the needed care through its own doctors and facilities.

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Receiving Health Care Outside the HMO

At some time you may wish to obtain health care services from a professional or facility not affiliated with the HMO, even though your HMO can reasonably provide the service. Whether the regular Medicare program will help pay for these services depends on the relationship between the Medicare program and the HMO you join.

Under some HMO contracts and under an HMO's Medicare "wraparound" package enrollees are not required to be "locked in" and may go outside the HMO for covered services. Although the HMO will pay for such care if it was not necessary for you to go outside the HMO, the Medicare program will provide its standard coverage for you. This means you will have to pay all the deductibles, co-payments or other charges which you must pay under regular Medicare coverage, even though you have already paid the HMO premium intended to be a substitute for the charges. If you plan to make frequent use of health care providers not affiliated with an HMO, it is probably not a good idea to enroll in one.

Many HMO contracts with Medicare require that Medicare beneficiaries enrolled in the HMO agree to be "locked-in" to the HMO. If you enroll in an HMO with this type of contract, Medicare will not pay anyone other than your HMO for your health care as

long as you are enrolled in that HMO. Therefore, if the HMO could have provided care, but you decided to go outside the HMO for services (except in a medical emergency or for an unexpected problem requiring prompt attention while you were away from the service area), neither the HMO nor Medicare will help pay for that care. You will have to pay all of that bill yourself. Approximately 100 HMOs currently contracting with Medicare have contracts with a "lock-in" requirement, and Medicare is working actively to encourage more contracts of this type. Be sure you know if your HMO has a "lock-in" requirement.

The "Lock-In" Advantage

Although it might be possible for you to enroll in an HMO where Medicare will pay for services received outside the HMO, there can be an advantage to joining an HMO with a "lock-in" requirement. **If an HMO having the "lock-in" feature provides health care to its Medicare beneficiaries less expensively than other providers in the same area, the HMO is required by Medicare to either reduce the premium paid by the enrollees or include coverage for extra benefits not covered by**

the regular Medicare program without increasing the premium charged to members. This means that the HMO, at no additional cost to you, might provide regular physical exams, vision and hearing check-ups, prescription drugs, or other services not covered by regular Medicare. The choice of which specific extra services will be offered is up to the HMO. By joining an HMO with the "lock-in" feature, you may enjoy important cost savings and/or benefit advantages.

HMO Benefit Options

Some HMOs offer Medicare enrollees only a single ("standard") schedule of benefits. Many others offer a choice between a "low option" plan at a lower premium and a "high option" plan covering additional benefits for a higher premium. A few HMO's offer Medicare enrollees a choice between more than two benefit options.

• Low Option

The low-option benefit package (or "standard benefit package" if no choice is offered) generally covers at least the services included under the regular Medicare program. Such options may, however, also include extra

benefits such as preventive check-ups not covered under regular Medicare. Enrollees in HMOs with the "lock-in" provision may have some or all of the extras offered in these plans at no additional cost. In some instances when extra features are provided (including a few of the HMOs with the "lock-in" feature), the premium charged by the HMO will be somewhat higher to offset the cost of providing extra benefits. The Medicare program, however, discourages HMOs from including extra benefits in their "standard" or "low option" plans if, as a result, the premium is so high that it discourages enrollment by Medicare beneficiaries.

• High Option

If one or more "high option" plans are available through the HMO, benefits offered by these plans will include services not covered by either the regular Medicare program or the HMO's "low-option" plan. The premium you pay will reflect the costs of providing additional services, but may still present a good value. Before deciding which plan is best, carefully compare the costs and benefits of the plans available to you.



Your HMO Rights Under Medicare²

Medicare beneficiaries have a number of important rights as members of HMOs contracting with the Medicare program. If you are now a member or are considering becoming a member of a Medicare-contracted HMO, make sure you are aware of your rights to:

1. Enroll Regardless of Your Health

Eligible Medicare beneficiaries applying to enroll in the low-option or standard benefit plan may not have their applications denied because of poor health (see discussion of eligibility on page 6). Persons deemed to be in poor health by their HMO may be denied participation in a high option plan, however. If a beneficiary is turned down for a high option plan because of a health problem, the HMO must allow membership in the low option plan instead.

² This discussion of "Your HMO Rights Under Medicare" applies ONLY to Medicare beneficiaries applying to enroll, or enrolled in, HMOs contracting with the Medicare program. If you are applying to enroll, or are enrolled in, an HMO that does not contract with Medicare, but rather has a "wraparound" package, your rights may be different. You should ask the HMO about all the rights discussed here.

2. Prompt Access to Medically Needed Services

The HMO must make available and accessible all covered services, if medically needed, to its enrollees with appropriate promptness at any time of day, any day of the week. This does not mean you can insist upon seeing a doctor at 4:00 AM if the visit can be postponed safely. There must be, however, a reasonable system through which you can contact the HMO at any time.

3. Stay Enrolled

The HMO cannot force you to drop your membership, nor refuse to renew your membership because you are in poor health or require a large amount of medical care. Your right to stay enrolled is protected by Medicare, even if you are in the high option plan, or if you develop end-stage kidney disease while you are enrolled in the HMO. However, if you fail to pay your HMO premium or any required co-payments; if you stop paying the Part B (Medical Insurance) Medicare premium; if you move to a residence outside the HMO service area; or if you provide false information in applying for your HMO membership, you may be terminated from HMO participation. Also, your membership may be cancelled if the contract between your HMO and the Medicare program is ended. If your membership is ended for this last reason, you will receive written notification at least 60 days in advance.



4. End Your Membership

You have the right to return to the regular Medicare program if you choose. To do so, you must notify the HMO in writing. The change will not take effect immediately, but usually will start on the first day of the month after your HMO has had written notification for a full calendar month. For example, if the HMO receives your letter on August 12, in most cases you will cease to be a member at 12:01 AM on October 1. If you intend to cancel your HMO membership for any reason, get in touch with the HMO as soon as possible to get full instructions.

5. Appeal HMO Decisions

Your HMO must have an established procedure for hearing and resolving member complaints. Ask your HMO for a description of its complaint-handling procedures. If you are dissatisfied with an HMO decision about a complaint, you have the right to appeal the decision to Medicare if the complaint involves any of the following:

- HMO failure to reimburse you adequately for costs of emergency or urgently needed services you had to get and pay for outside the HMO because you could not use the HMO reasonably to receive care;

- HMO failure to reimburse you adequately for the cost of a medical service covered by Medicare that you think you needed and that you received and paid for outside the HMO because the HMO refused to provide the service;
- HMO refusal to provide you a service covered by Medicare that you think you need; or the failure of the HMO to respond within 60 days to your request for a covered service.

An HMO may refuse your membership if they currently have reached their limit on the number of Medicare beneficiaries enrolled. If you feel your HMO rights have been violated any Social Security Office can help you request a review by Medicare. If your complaint involved more than \$100, you have additional rights to appeal Medicare's findings if you disagree with the decision. These are explained more fully in "Your Medicare Handbook."

Supplemental Health Insurance

HMO members are much less likely to need private supplemental insurance plans (sometimes referred to as "Medigap" insurance) that pay all or part of the

deductibles and co-payments required under regular Medicare, since HMO members encounter few, if any of these expenses. These private supplemental plans would be useful only if you were enrolled in an HMO without the "lock-in" requirement and planned to make fairly frequent use of non-HMO providers. In this case, you would be relying on regular Medicare and private supplemental insurance to cover the additional expenses.

In most instances, however, it would not be economical to continue paying the premium for "Medigap" type insurance as a member of an HMO. If you are planning to keep the supplemental insurance (after careful review of the benefits and costs) be sure to check the "Coordination of Benefits" provisions of both the private insurance and HMO plans. "Coordination of Benefits" provisions often are included in insurance contracts to avoid duplicate payments for services.

If you decide to cancel your private supplemental Medicare insurance, try to find out from your insurance company whether there would be any problem in getting back your coverage if you change your mind. Sometimes there are delays in renewing your policy or waiting periods before coverage goes into effect that may cause you to keep your private policy temporarily, until you decide whether you like the HMO.

Advantages of HMO Membership

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There are many reasons why enrolling in an HMO may be an excellent choice for Medicare beneficiaries. This section will discuss the particular advantages of HMO membership for older citizens. But HMOs are a different way to receive health care, and the next section will identify some of the areas where adjustments are required.

A Budget for Your Health Care Expenditures

Medicare HMO enrollees pay a specified premium to the HMO and the Part B Medical Insurance premium to Medicare. There are few, if any additional HMO deductibles or co-payments so the amount you pay for covered health services obtained through an HMO will not vary significantly with the amount of services you use.

For example, Mrs. Smith spent \$50 dollars in April for doctor visits, \$500 in June for 4 days in the hospital, and \$150 in July for eye care services. All of this was in addition to her monthly Medicare Part B premium. Had Mrs. Smith been enrolled in an HMO, her health care expenses for the four months would have been the Medicare Part B premium plus the HMO premium.

Knowing in advance how much you will be paying for health care can be important for persons living on fixed incomes.

Preventive Health Care

Just as their name implies health maintenance organizations stress staying healthy rather than focusing entirely on treating sickness. The fixed amount of money paid to HMOs each month is not increased if they provide more services. Consequently, HMOs have incentives to keep their members healthy and to treat problems that do arise quickly, before they become more serious and costlier.

A growing number of HMOs are including preventive care among their benefits for Medicare beneficiaries (although some are required by the Medicare program to exclude from their low option plans benefits not covered by regular Medicare, including preventive services). Many HMOs also provide free or low cost health education programs, and some have special programs designed to help older members learn to help themselves stay healthy and active.



No Medicare "Assignment" Problems

Older people not enrolled in HMOs sometimes have trouble finding a doctor willing to accept Medicare "assignment". Doctors now are taking Medicare assignment less than half the time. If a doctor refuses to accept Medicare assignment, you can be charged more for services than Medicare approves. In such cases you are responsible for paying all of the amount charged by the doctor in excess of the limits set by Medicare, as well as the Medicare deductibles and co-payments. Also, you will have to pay the entire bill when it is presented and wait for reimbursement from Medicare for its share of the cost.

HMO enrollees, on the contrary, are charged little or nothing at all for covered doctor services received through their HMOs. Medicare assignment is explained more fully in "Your Medicare Handbook."

No Medicare Claim Forms

HMO enrollees do not have to fill out and submit Medicare Form 1490S (Patient's Request for Medicare Payment). In spite of Medicare's efforts to make the process for filing claims as simple as possible, some people still find it confusing. As long as you use HMO doctors you will not have to submit Medical Insurance (Part B) claims to Medicare. Nor will you have to wait to be reimbursed for payments you had to make to physicians who refused Medicare assignment.

Improved Coordination of Services

The rapid advances in knowledge and tools of medical science make the choices more and more difficult for the health care consumer. Deciding which practitioner to see, where to find the care you need and how to pay for health care services pose problems for even the most informed person. When you join an HMO, your personal HMO doctor will

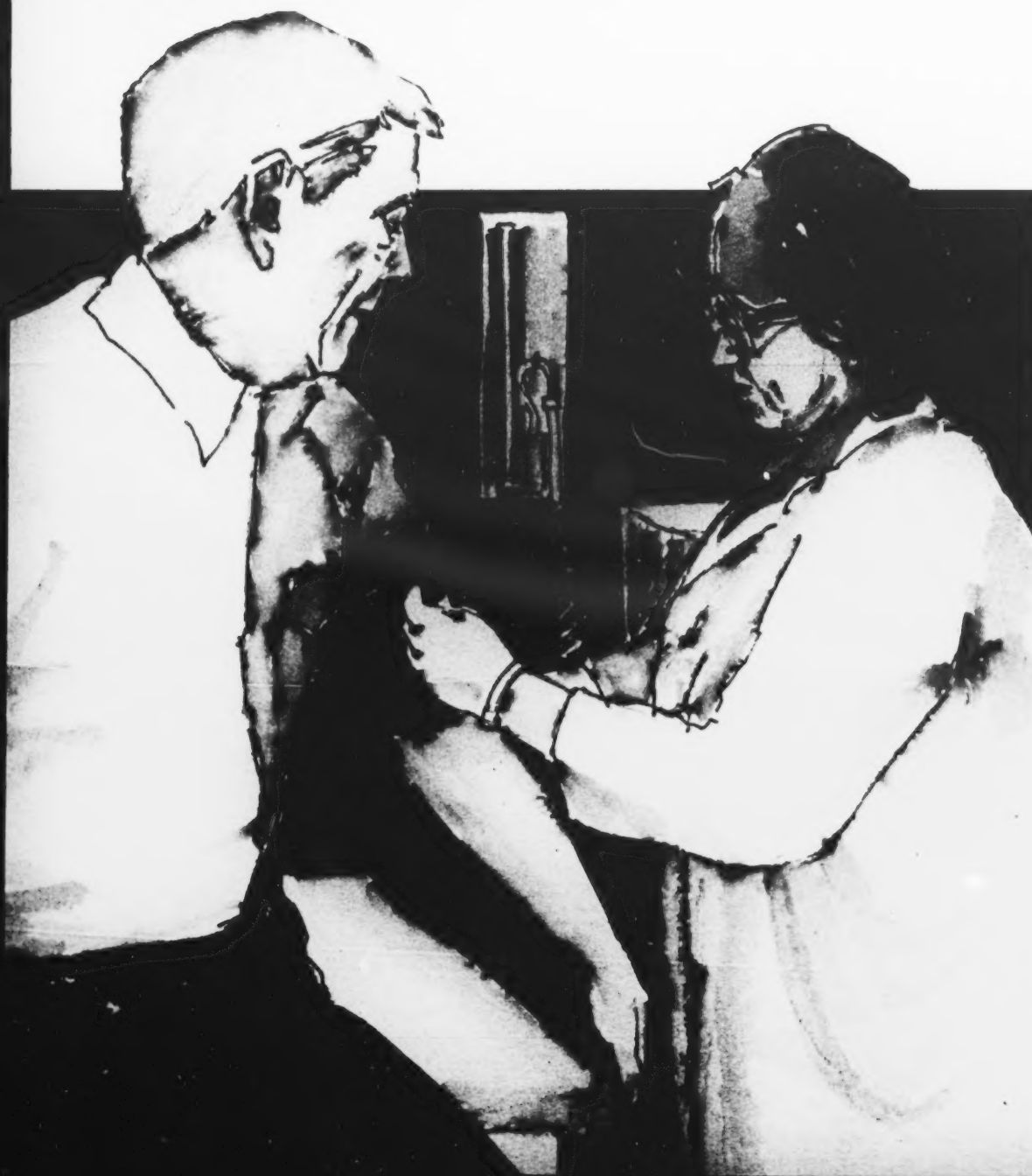
coordinate all the care you receive through the HMO and make sure that you are directed to the health professional who can best meet your special needs. All the lab tests, x-rays, and other services you'll need will be provided through the HMO. The guidance of a personal HMO physician and the availability of comprehensive services can be especially helpful for older persons needing more frequent and varied health care.

Less Time in the Hospital

HMOs are helping to reduce the average time spent by patients in hospitals. Older enrollees, who are more likely to be hospitalized than younger people, can especially appreciate the advantages offered by the HMO. By providing broad coverage on an outpatient basis as well as for inpatient care, and monitoring hospital use to assure appropriate care, HMOs help reduce the hospital dependency of their enrollees.

Extra Benefits Or Reduced Premiums

As mentioned before, many of the new Medicare contracts with HMOs include special incentives to encourage Medicare beneficiaries to enroll. If Medicare determines that the HMO is providing the same health care services covered by regular Medicare at a lower cost than other providers in the area, the Medicare-contracting HMO must reduce the premium paid by Medicare beneficiaries in the plan or offer extra benefits with no increase in costs. Some HMOs may offer extra benefits such as vision or hearing check-ups, immunizations, dental care, etc.



Assuring Quality

HMOs contracting with the Medicare program have formal programs to monitor the quality of care provided by their doctors and hospitals. With rare exceptions, studies of the care provided by HMOs find the quality equal to or in excess of community standards.

Adjusting to HMO Membership

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For many people an HMO is a new and different way of receiving health care. Every HMO has policies and procedures to assure that its members have access to services and that these services are used appropriately. For most of us, this will mean a major change. In deciding whether to join an HMO, you need to weigh the advantages against the new ways of doing things that you will encounter in an HMO.

Limited Access to Providers Not Affiliated with the HMO

With the regular Medicare program, you may seek care from any licensed physician or Medicare approved facility. This same coverage applies regardless of the provider utilized (although you likely will pay more if your doctor does not accept assignment from Medicare). HMO members, however, incur additional expenses if they use doctors, hospitals or other facilities not affiliated with their HMOs. Therefore:

IF you have used the same doctor for a long time and established a close and trusting doctor-patient relationship;

IF you are comfortable discussing all your health concerns with your doctor and his or her assistants;

IF you are happy with all your present arrangements for receiving health care, and;

IF you do not find the financial limitations of Medicare coverage particularly burdensome;

you should think very carefully before joining an HMO that would not allow you to use your present health care providers. Of course, if your present doctor is affiliated with an HMO that you can join, this will not be a problem.

Limited HMO Locations

Getting to and from the doctor's office sometimes is a problem for persons with limited access to transportation. An HMO with centralized health centers may require more travel than usual to receive health care. Before you enroll, you should determine how you will travel to the HMO and whether such travel imposes a burden.

Limited Coverage When You Travel

Some older people spend a great deal of time away from home, traveling either for business or pleasure. The HMO usually will not cover expenses for health care needs you could have recognized before going on your trip or care that might be postponed safely until you get home. Your HMO will pay for care you get from providers not affiliated with your HMO in the case of a medical emergency or for a serious problem arising unexpectedly while you are away from the HMO's service area.

If you have a chronic problem and know in advance that you'll need medical attention while you are traveling, your HMO will arrange for you to receive care from an HMO in the area you will be visiting. If you like to travel, find out about the restrictions on coverage outside an HMO's service area before you join.

The Role of Physician Extenders

Some HMOs make extensive use of specially trained nurse practitioners and physician assistants to handle many routine office visits. These practitioners are called "physician extenders". Some people want to



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see a doctor when they need care. If you are concerned about this, ask the HMO to explain its policy on physician extenders before you sign up. As you consider this point, however, it is important to know that these professionals often spend more time with patients than doctors. They are concerned that the patients understand all aspects of the care they receive; and some physician extenders have special training in work with older patients.

Limited Experience with Older Patients

Approximately six percent of the people enrolled in HMOs are over 65 years of age. For this reason, most group practice HMO doctors do not get to see many elderly patients. Thus, they may be less accustomed to the special needs and preferences of older persons. Of course, many HMO doctors were in private practice and worked with older patients before their HMO affiliation, and Independent Physician Association (IPA) doctors may still work with older patients in their private practices. Also, all doctors had some experience with older patients as part of their clinical training. Any concerns you have about this should be raised with the HMO.

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Before You Join an HMO

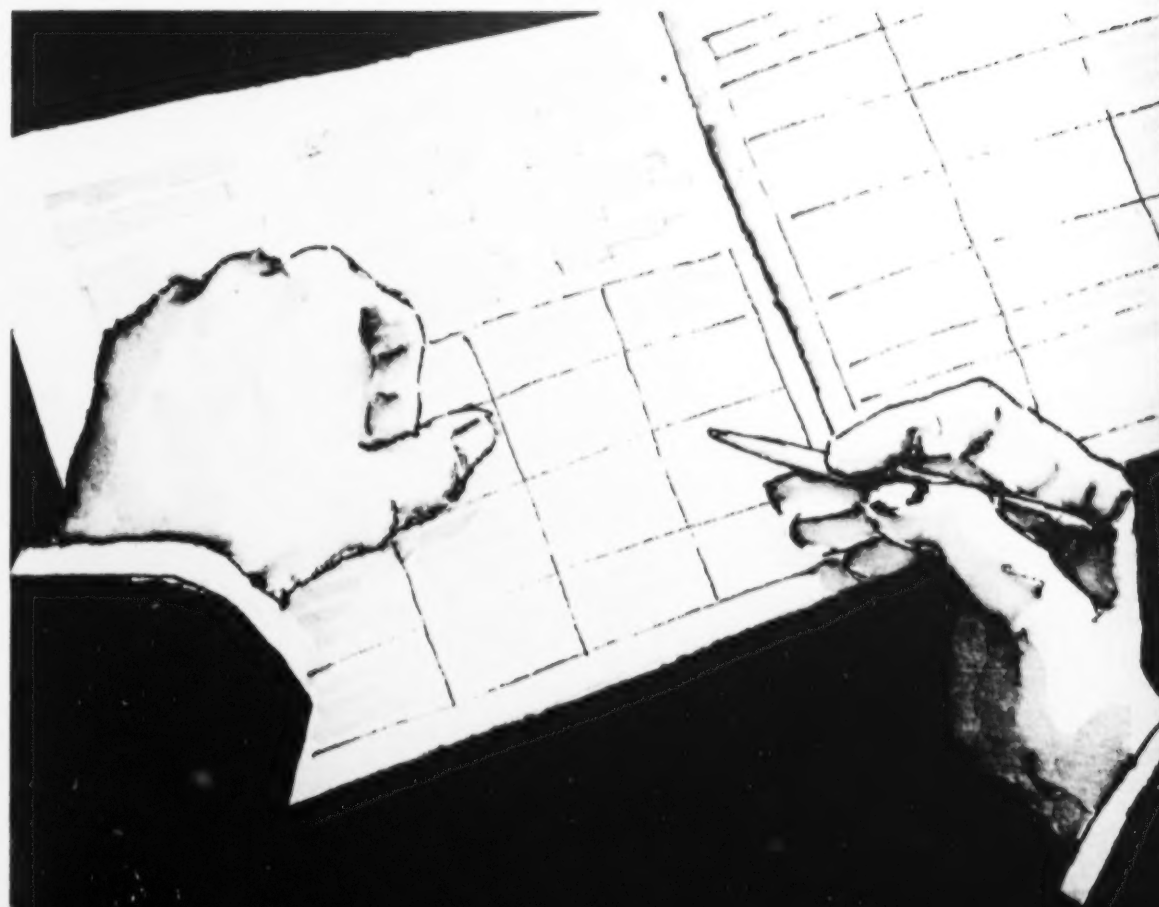
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If membership in an HMO seems attractive to you after all you have read so far, it is time to take a closer look at the specific HMOs you are eligible to join. Your local Social Security Office can help you identify these, or you can ask the HMOs in your area about their policies regarding Medicare beneficiaries.

Each HMO is different. They each use different doctors and hospitals, charge different premiums, and have different administrative policies. You will want to examine the HMOs you are thinking of joining and consider how they compare with regular Medicare and each other.

To find out about a particular HMO, talk to its staff members. Often there is a member services department set up to answer such queries. Carefully read all the literature an HMO publishes describing its costs and services. Also, try to talk to people who are (or have been) members of the HMOs you are considering.

To help you get started, we have developed some questions you may want to ask before you make your decision. Look them over and decide which are the most important to you. Be sure to ask about anything that concerns you—whether or not it is covered by our list.



Questions for HMO Staff

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To the right of each question, check (☒) when you have received the necessary information.

1. Benefits and Costs of Low Option or Standard Plans

Did you find out:

- ☐ The premium you'll pay? _____
- ☐ Whether co-payments are required? _____
- ☐ If so, how much and for which services? _____

■ Use this guide's worksheet to compare total HMO costs with the amount you would pay under regular Medicare. You may wish to make additional cost projections comparing your HMO costs with your costs under regular Medicare if you needed substantially more medical care in the near future.

2. Benefits and Costs of High Option Plans

Did you find out:

- ☐ Whether the HMO has a high option plan? _____
- ☐ Which benefits are included that are not part of the low option plan? _____

- ☐ How much more the high option plan costs? _____
- ☐ Whether the HMO restricts eligibility for the high option plan? _____

3. Qualifications of Doctors Affiliated with the HMO

Did you find out:

- ☐ What proportion of the doctors are board certified or board eligible? _____
- Doctors who are board certified have completed specialty training and passed examinations testing their knowledge in a particular specialty; doctors who are board-eligible have completed training but not yet passed the examination.
 - ☐ Whether the HMO has physicians with the following specialties:
 - surgery? _____
 - eye care? _____
 - orthopedics? _____
 - skin care? _____
 - mental health? _____
 - other fields that might effect your personal needs? _____

4. HMO Staff Turnover Ratio

Did you find out:

- ☐ The number of doctors affiliated with the HMO a year ago who are no longer there? _____
- ☐ The total number of doctors affiliated with the HMO? _____

■ These figures will give you an idea of staff turnover and suggest whether the physician you select is likely to remain with the HMO for the foreseeable future.

5. Choosing Your Personal HMO Doctor

Did you find out:

- ☐ Whether you will be allowed to choose your personal HMO doctor from those affiliated with the HMO? _____
- ☐ If your choice will be restricted in any way? (For example, some doctors may not be accepting new patients.) _____
- ☐ Whether you must pick a primary care doctor or can you choose a specialist? _____
- ☐ Whether you can change your physician if you are unhappy with the one you selected? _____

- ☐ If there is a limit on how often you can switch HMO doctors? _____

6. Doctor's Location

Did you find out:

- ☐ Whether you have a choice of locations? _____
- ☐ How long it will take to get there from your home? _____
- ☐ Whether you can travel conveniently to the HMO location? _____

7. Lock-In Provision

Did you find out:

- ☐ Whether Medicare will pay for care you get from a provider or facility not affiliated with the HMO? _____

8. Physician Extenders

Did you find out:

- ☐ Whether nurse practitioners or physician assistants handle routine office visits? _____
- ☐ What the policy is if a patient wishes to see a doctor instead? _____
- ☐ Whether any of the physician extenders had special training in working with older patients? _____

9. Waiting Time for Appointments

Did you find out:

- ☐ How long the usual waiting period is before you can get an appointment with your personal HMO doctor? _____
- ☐ How long you'll wait when you have a special problem? _____
- ☐ How long it takes to get an appointment for a check-up? _____

10. Patients' Special Needs

Did you find out:

- ☐ Whether the HMO has a barrier-free entry? _____
- ☐ If the HMO staff can communicate with members who do not speak English? _____

11. Hours of Operation

Did you find out:

- ☐ When the HMO is open regularly? _____
- ☐ What provisions are made for receiving care when the central location is closed? _____
- ☐ Whether all services are available during normal business hours, or are some services available only at specified times? _____

- ☐ If you can telephone your HMO doctor or physician extender with a question about your care? _____
- ☐ If there are special times set aside for these calls? _____

12. Other Services Offered

Did you find out:

- ☐ If the HMO provides any of these services at the same location as doctor services:
- X-ray? _____
- Pharmacy? _____
- Health Education? _____
- Eyeglasses? _____
- Other services you may need? _____

13. Specialist Services

Did you find out:

- ☐ Where you will have to go for care if you have a serious or chronic health problem requiring the attention of a specialist? _____
- ☐ What provision is made if the HMO is not affiliated with the particular specialist you might need? _____
- ☐ If the HMO will pay for a second opinion on a recommended treatment? _____

- ☐ Whether the second opinion has to be from another doctor affiliated with the HMO, or can you seek an outside opinion? _____

14. Hospitals Used by the HMO

Did you find out:

- ☐ Where you would go for hospital care? _____
- ☐ Whether these facilities have intensive care units? _____

■ When you find out which hospitals are used by the HMO, consider whether this hospital is convenient for family and friends who might visit you, and whether the hospital is one you would want to use.

15. Skilled Nursing Facilities Used by the HMO

Did you find out:

- ☐ Which nursing facilities are used by the HMO? _____

■ When you find out which nursing facilities are used by the HMO, consider whether this is convenient for your family and friends who might visit you, and whether the nursing facility is one you would want to use.

16. Policies on Health Care Received Away from the HMO Service Area

Did you find out:

- ☐ Whether you must obtain permission from the HMO before receiving non-emergency care? _____
- ☐ How you will arrange for out-of-town care? _____
- ☐ What documents must be submitted for reimbursement of your out-of-pocket expenses for care received while away from home? _____
- ☐ If there is a time restriction on submitting these expenses? _____
- ☐ How long it takes to be reimbursed? _____

17. Member Satisfaction with HMO

Did you find out:

- ☐ The proportion of HMO members—both Medicare beneficiaries and other—who have dropped out voluntarily during the past year? _____

■ Keep in mind that some people discontinue their membership because they are no longer eligible.

18. Dropping Your Membership

Did you find out:

- ☐ How much notice you need to give? _____
- ☐ Whether your membership continues long enough after cancelling for you to make other arrangements for health care and health insurance? _____
- ☐ Whether you can re-join the HMO if you leave the area and return? _____

19. Change in Health Status

Did you find out:

- ☐ If there are conditions that will make you ineligible for high-option membership? _____
- ☐ If there are conditions that the HMO will not treat? _____

20. Handling Complaints

Did you find out:

- ☐ What the major complaints have been during the past year? _____

21. HMO History and Organization

Did you find out:

- ☐ How many members the HMO has? _____

Questions for HMO Members

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- ☐ Which companies offer membership as an employee benefit? _____
- ☐ How long the HMO has provided services to Medicare beneficiaries? _____
- ☐ How many members are Medicare beneficiaries? _____
- ☐ Which groups are represented on the HMO Board of Directors? _____
- ☐ If HMO members have a seat on the Board? _____
- ☐ If there is a members' advisory commission to the Board? _____
- ☐ If older people are members of the commission? _____

22. Visiting the HMO

Did you find out:

- ☐ Whether the HMO (group practices only) will schedule a visit so you can see and evaluate the facility for yourself? _____
- The HMO may have an "open house" so you can tour the facility and ask questions. When you visit the HMO, look for cleanliness, convenient public transportation, parking, architectural barriers, stairs, number of people waiting for service, etc. _____

As you consider HMO membership, it may be helpful to talk with current or former members of the HMO you are investigating. They will be able to tell you what they like most and what they like least about the HMO, and can probably answer the following questions:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Did the HMO's physicians and other care providers treat you with courtesy and deal with you honestly? | ☐ | ☐ |
| 2. Were your questions answered directly and promptly? | ☐ | ☐ |
| 3. Did you have access to doctors when necessary? | ☐ | ☐ |
| 4. Were appointments for urgent care scheduled quickly? | ☐ | ☐ |
| 5. Was the waiting period for routine check-ups reasonable? | ☐ | ☐ |
| 6. How difficult was it to get a call through to make an appointment or ask a question? | ☐ | ☐ |

7. Can you call your HMO doctor or physician extender when you have a question about your care? ☐ ☐

8. Do you enthusiastically recommend membership in the HMO for other Medicare beneficiaries? ☐ ☐

Conclusion

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Most HMOs will want you to enroll only after you have been fully informed and satisfied that HMO membership is the best health care choice you can make. They know that misinformed or insufficiently informed members file more complaints; provide negative and misleading information to prospective members; and are likely to drop their membership before getting to know and fully utilize the benefits offered by the HMO. If you decide to join an HMO, as a knowledgeable member you will be able to take full advantage of the health care available to you through the HMO; realize the economic savings that might accrue through HMO membership; and fairly represent the HMO to other older citizens seeking information. Of course, you may decide not to participate in an HMO, as a result of careful consideration and weighing the advantages and disadvantages.

In either case, we hope the information provided in this booklet about health maintenance organizations will help your decision-making process. Informed health care consumers have an important part to play in improving the quality and cost of services for everyone.

Comparing Health Benefits & Costs

Use this worksheet to compare costs for health services obtained through regular Medicare with the costs of services through an HMO. Figures for your Medicare premiums and co-payments are accurate as of January 1986. Remember that the amount you'll pay for Medicare co-payments and deductibles changes periodically. As you collect premium and cost information from HMOs in your area, fill in the blanks, and use this information to compare the costs for HMO services with the costs for services received elsewhere.

+ There may be additional limits, under Medicare or HMO, for some services, such as mental health care—check "Your Medicare Handbook" and HMO benefit description carefully. Also Medicare costs shown in table are for 1986. Costs are subject to change every year.

++ HMO services when provided by HMO, except in medical emergency or upon referral by HMO.

* Benefit period begins on 1st day you receive care as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row. You must have been

hospitalized for at least 3 days before benefit period begins for skilled nursing facility.

** 60 lifetime reserve days under Medicare may be used only once. HMO may not have this limit.

*** Once you have paid \$75 for covered services in a calendar year, the Part B deductible does not apply to any additional covered services you receive in the same year.

**** Reasonable charges are determined by Medicare (see "Your Medicare Handbook").

I. PREMIUMS	You pay the following premiums, co-payments and deductibles for services through:+			
	Regular Medicare \$15.50/month Medicare part B	Medicare Supplemental Insurance \$_____ month	HMO I** \$15.50/month Medicare part B \$_____ month HMO premium	HMO II** \$15.50/month Medicare part B \$_____ month HMO premium
II. BENEFITS				
A. Part A (Hospital Insurance)				
1. Inpatient Hospitalization Each Benefit Period *				
1st day - 60th day	\$492 TOTAL			
61st day - 90th day	\$123/day			
91st day - 160th day**	\$246/day			
Additional days	ALL COSTS			
2. Skilled Nursing Facility Each Benefit Period* (after hospitalization)				
1st day - 20th day	Nothing			
21st day - 100th day	\$61.50/day			
Additional Days	ALL COSTS			

	Regular Medicare	Medicare Supplemental Ins.	HMO I**	HMO II**
3. Home Health Care (after Hospitalization)	Nothing			
4. Private Duty Nursing	ALL COSTS			
5. Blood (FOR BENEFIT PERIOD)* First 3 pints	ALL COSTS			
Additional pints	Nothing			
B. Part B (Medical Insurance)				
1. Preventive visits to Doctor				
a. Routine physical exams	ALL COSTS			
b. Routine lab tests	ALL COSTS			
c. Most immunizations	ALL COSTS			
d. Routine foot care	ALL COSTS			
e. Routine eye exams	ALL COSTS			
f. Routine hearing exams	ALL COSTS			
2. Routine dental care	ALL COSTS			
3. Doctor services for medical or surgical treatment of injuries or illness while you are in hospital or in skilled nursing facility	\$75 deductible*** plus 20% of reasonable charge**** after deductible plus 100% of costs over reasonable charge if your doctor doesn't accept assignment			
4. Doctor services for medical or surgical treatment of injuries or illness at doctor's office, including X-rays, lab tests, medical supplies and medications that must be administered during visit.	Same as B3			
5. Doctor services (as described in B3) provided at your home when medically necessary	Same as B3			
6. Hospital emergency room or outpatient department services (except preventive)	Same as B3			

continued

B. Part B (Medical Insurance)	Regular Medicare	Medicare Supplemental Ins.	HMO I + +	HMO II + +
7. Physical & speech therapy	Same as B3			
8. Medically necessary ambulance service	Same as B3			
9. Home Health Care	Nothing if ordered by physician			
10. Outpatient Mental Health Services	50% of the charge up to maximum of \$500 per year			
11. Other Medical Expenses a. Prescription drugs b. Eyeglasses c. Hearing aids	ALL COSTS ALL COSTS ALL COSTS			



HEALTHY US

"Healthy US" is the major national campaign of the American Association of Retired Persons to help reduce the skyrocketing health care costs that are weakening our health care system and our national economy. The campaign includes political and consumer action, and health promotion activities. To learn how you can help, write "Healthy US," AARP, 1909 K Street, N.W., Washington, DC 20049.

Health Advocacy Services
Program Department



American Association
of Retired Persons
1909 K Street, N.W.
Washington, DC 20049

LEADER TEACHING GUIDE

V. SENIOR CITIZENS AND HEALTH CARE COVERAGE

C. SHOPPING FOR A MEDICARE SUPPLEMENT POLICY

Lesson Outline

Many senior citizens for whom Medicare is their primary form of health care coverage also purchase a policy to supplement Medicare's gaps in coverage. These are also known as Medigap or Medifill policies and are widely advertised on TV, radio, and in the mail. A good Medicare Supplement Policy can help to pay some (but not all) of the costs Medicare doesn't pay. The U. S. Health Care Financing Administration of the U. S. Department of Health and Human Services offer the following "tips" for Medicare enrollees when considering additional insurance:

- I. Do Not Buy More Policies Than You Need
 - A. Expensive
 - B. Duplicate coverage
- II. Check for Pre-existing Condition Exclusions and Waiting Periods
 - A. Know when coverage begins
 - B. Get information in writing
- III. Be Careful About Replacing Existing Coverage
 - A. Usually a waiting period
 - B. May need to take a physical
 - C. Keep old policy in force until new one is in effect

Suggested Learning Activities

Unless otherwise designated, the materials listed are for the leader's use and do not need to be duplicated unless the leader chooses to do so.

Read "Guide To Health Insurance For People With Medicare," prior to presenting lesson. Additional free copies available from local Social Security offices.

Display and discuss Exhibit V-I, "Shopping Tips For A Medicare Supplement Policy" - may be made into a transparency.

Duplicate and distribute "Shopping Tips For A Medicare Supplement Policy." Allow discussion on personal experiences with this type of protection.

IV. Be Aware of Maximum Benefits

- A. Can be maximum payments
- B. May be maximum number of days or visits

Secure Medicare Supplement Policy (or Blue Cross/Blue Shield Medigap Explanation of Benefits) or Medicare Supplement Policy Advertisement.

V. Check Your Right To Renew

- A. Avoid policies "renewable at company option"
- B. Look for "guaranteed renewable" and "noncancellable."

Duplicate and distribute "Medicare Supplemental Insurance Comparison Worksheet" from the People's Medical Society.

VI. Beware of Implied or Actual Claim of Endorsement by U. S. Government

- A. Federal government does not endorse insurance policies or companies
- B. Official-looking envelopes with a Government "Seal" can be misleading

In small groups or as a class, use worksheet to evaluate samples.

NOTE: You may make a transparency of this worksheet and use it to evaluate sample(s) as a class activity.

VII. Take Your Time

- A. Don't be high pressured
- B. Beware of "last chance to enroll"

VIII. Beware of "Scare Tactics"

- A. Don't be frightened by advertising or hard sell
 - 1. Less than 2% of elderly exhaust Medicare inpatient hospital benefits
 - 2. Only 4% of elderly are in nursing homes

IX. Do Not Withhold Medical Information

- A. Be complete and accurate
- B. If withheld, may lead to non-payment on a claim

X. Get A Written Outline of Coverage

- A. Read it carefully
- B. Ask a friend or relative to review it with you

XI. Do Not Pay Cash

- A. Pay by check, or money order, made out to insurance company
- B. Keep information on agent and company to follow up

For more information, refer to:

XII. Make Sure There Is A "Free Look" Provision

- A. Should allow at least 10 business days to review policy and return for full refund of premium

"Ways To Pay What Medicare Won't," Changing Times. October, 1983. p. 85-88.

- B. Return policy and cancel in writing; keep a record

"Medicare - Supplement Insurance," Consumer Reports, June, 1984. p. 347-355.

XIII. Be Aware of Illegal Sales Practices

- A. Agent suggests he or she represents Medicare program
- B. Knowingly sells a duplicate policy

Policywise by Nancy H. Chasen. Scott, Foresman and Company, 1983.

EXHIBIT V-1

**SHOPPING TIPS FOR A
MEDICARE SUPPLEMENT
POLICY**

1. DO NOT BUY MORE POLICIES THAN YOU NEED.
2. CHECK FOR PRE-EXISTING CONDITIONS,
EXCLUSIONS, AND WAITING PERIODS.
3. BE CAREFUL ABOUT REPLACING EXISTING COVERAGE.
4. BE AWARE OF MAXIMUM BENEFITS.
5. CHECK YOUR RIGHT TO RENEW.
6. BEWARE OF THE "GOVERNMENT LOOK."
7. TAKE YOUR TIME.
8. BEWARE OF "SCARE TACTICS."
9. DO NOT WITHHOLD MEDICAL INFORMATION ON
APPLICATION.
10. GET A WRITTEN OUTLINE OF COVERAGE.
11. DO NOT PAY CASH.
12. MAKE SURE THERE IS A "FREE LOOK" PROVISION.
13. BE AWARE OF ILLEGAL SALES PRACTICES.

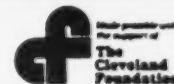


Making Sense of Health Care Plans:

THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE

OCCES OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



SECTION V-C

SHOPPING TIPS FOR A MEDICARE SUPPLEMENT POLICY

If you rely solely on Medicare for your health insurance needs and are looking for additional protection, the Health Care Financing Administration, the federal agency that administers the Medicare program suggests the following thirteen hints be considered when shopping for private Medicare supplemental insurance (sometimes called Medigap or Medifill policies):

SHOPPING HINT #1

Do Not Buy More Policies Than You Need

Many policies have a "coordination of benefits" clause--the policy will not pay when another insurer pays or each insurer will pay part of the costs, not to exceed total actual cost.

Duplicate coverage is costly--this often means multiple premiums with no greater protection than a single good policy.

SHOPPING HINT #2

Check For Pre-existing Condition Exclusions and Waiting Periods

Be sure you know:

When the new policy begins paying.

If any medical conditions are permanently excluded or not payable until a future date.

You have this information in writing.

SHOPPING HINT #3

Be Careful About Replacing Existing Coverage

There is usually a waiting period.

Your current medical condition may affect your new coverage.

However, do not keep an inadequate policy just because you have had it a long time. If you do replace it, keep the old policy in force until the new one becomes effective.

SHOPPING HINT #4

Be Aware of Maximum Benefits

Many policies have maximum payment amount under the entire policy or for specific treatments. Some have maximum number of days or visits.

Get the maximums in writing to see if they meet your needs.

SHOPPING HINT #5

Check Your Right To Renew

Avoid policies "renewable at company option." The company could cancel your individual policy for any reason at the end of the policy year or when the premium comes due.

SHOPPING HINT #6

Beware of Implied or Actual Claim of Endorsement by United States Government

Federal government does not endorse insurance policies or companies.

Advertising literature designed to look "governmental"

- Social Security envelope size
- Official-looking seal
- Correspondence begins with "Dear Medicare Member"

Remember

No private insurance company selling insurance to add to Medical is affiliated with or endorsed by the Federal Government.

A Federal seal on a policy does not mean government endorsement.

SHOPPING HINT #7

Take Your Time

Don't be "high pressured."

Beware of "last chance to enroll" statements. Ethical salespeople never "high-pressure" you.

Shop carefully and compare policies for what they cover and what they cost.

Buying insurance is an important decision. Take enough time to feel confident about your choice. Consult others if you can before you buy.

SHOPPING HINT #8

Beware of "Scare Tactics"

Agent or advertising literature describes extreme situations to frighten the purchaser.

- Exaggerated expenses
- Exaggerated likelihood of illness

Remember

Less than 2 percent of the elderly exhaust the Medicare inpatient hospital benefits in any given year.

Only 4 percent of the elderly are in nursing homes.

Few private health insurance policies cover all services Medicare does not cover.

SHOPPING HINT #9

Do Not Withhold Medical Information

Withholding medical information on a policy application may lead to nonpayment for a later claim.

Never believe salespersons who say you don't have to furnish such information when the application requests it, or say they will fill in that information later.

SHOPPING HINT #10

Get a Written Outline of Coverage

Always ask for a written description of the policy you are considering buying--in simple language.

A company selling a good policy will always provide a simplified description of what they are offering for sale.

Read it carefully.

SHOPPING HINT #11

Do Not Pay Cash

Always pay by check, money order, or bank draft made out to the insurance company--never to the agent or anyone else.

Always write down the name, address and telephone number of the agent or insurance company, so you can follow up if there is any delay in getting your policy.

SHOPPING HINT #12

Make Sure There Is a "Free Look" Provision

Most reputable insurance companies give you at least 10 days after you receive your policy to look it over. During that time, if you decide you don't want it, you can return it for a full refund of your premium.

Beware of any insurance policy that is on a "take it or leave it" basis and does not give you a grace period to change your mind.

SHOPPING HINT #13

Be Aware of Illegal Sales Practices

Federal criminal penalties can be imposed against a company or agent who:

- suggests they represent the Medicare program or any Federal agency
- knowingly sells you a policy which duplicates Medicare coverage or any private health insurance you already own that will not pay duplicate benefits

Contact your State Insurance Department for further information or to report misleading practices. In Ohio, call the Ohio Department of Insurance's toll-free hotline at 1-800-282-4658.

MEDICARE SUPPLEMENTAL INSURANCE COMPARISON WORKSHEET

Use the information provided by the insurance companies to complete this worksheet

	Policy 1	Policy 2	Policy 3	Policy 4
Company Name				
Policy/Plan Name				
Premium: May be affected by age & sex				
Monthly	\$	\$	\$	\$
Quarterly	\$	\$	\$	\$
Semi-Annually	\$	\$	\$	\$
Annually	\$	\$	\$	\$
Does the Supplemental Policy Cover the Deductibles and Co-Payments listed Below?	If so, place a Checkmark in the appropriate column for each policy			
Medicare Part A: Hospital (1987 Amounts)				
Initial deductible \$520				
61 to 90th Day Co-Payment \$130/day				
91 to 150th Day Co-Payment \$260/day				
90% of Medicare approved expenses for additional 365 days				
Skilled Nursing Care 21st to 100th Day Co-Payment \$65/day				
Medicare Part B: Physician				
Initial deductible \$75				
20% Co-Payment				
Does the Supplemental Policy provide any additional benefits?	If so, place a Checkmark in the appropriate column for each policy			
Prescription drugs				
Private duty nursing				
Additional physicians' fees				
Skilled Nursing Care				
Number of days available	_____	_____	_____	_____

Closing the Gaps — in Your — Medicare Coverage

Prepared By:



Attorney General Anthony J. Celebrezze, Jr.
30 East Broad Street, Columbus, Ohio 43215 614/466-4320



Dear Fellow Ohioan:

More than 1.2 million Ohioans are covered by Medicare. But as many of you have found out, Medicare does not provide complete health-care coverage. In fact, it pays only about 40% of the average older citizen's health care bill. As a result, over two-thirds of all Ohioans covered by Medicare have turned to private insurance companies for additional coverage. These Medicare supplement policies, also known as Medigap or Medifill policies, cost Ohioans millions of dollars each year.

Older citizens are smart to supplement their Medicare coverage. Health care costs have risen at an alarming rate in recent years and the average senior citizen spends more on health care than do those of us under 65. But Medicare supplement policies can be confusing, and some unscrupulous insurance agents have taken advantage of the situation by misrepresenting their policies and selling Medicare recipients coverage which they already have.

This booklet was prepared to assist Ohioans with the purchase of Medicare supplement policies and to protect them against paying for duplicate coverage. It answers some important questions concerning the amount of coverage needed, where to purchase good coverage, and what benefits can be expected. Additional copies of "Closing the Gaps in Your Medicare Coverage" can be obtained by calling 614/466-4320.

Sincerely,

A handwritten signature in dark ink, appearing to read "Anthony J. Celebrezze, Jr." The signature is fluid and cursive, with the last name being particularly prominent.

Anthony J. Celebrezze, Jr.
Attorney General

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Where Are the Gaps?

Medicare coverage is divided into two parts: Part A covers benefits for necessary services during an overnight stay in a hospital or nursing home and services provided by a home health agency or hospice. Part B pays benefits for services such as doctor bills and medical supplies.

The services covered by Medicare are measured by "benefit periods," which begin when you enter the hospital and end when you have been out of the hospital, nursing home or rehabilitation facility for 60 consecutive days. Medicare will pay for up to 90 days of hospitalization for each benefit period. The 90 day period is then renewable when you start another benefit period. Medicare pays in full for the first 60 days, except for the deductibles described later in this booklet.

If you are hospitalized for longer than 90 days in a single benefit period, Medicare provides an extra 60 "lifetime reserve" days, subject to a \$200 deductible per day. These days are not renewable; once you use them they are gone.

Although Medicare provides good basic coverage, it is not designed to cover an entire medical bill. There are four types of gaps in the Medicare program where expenses are not covered.

- **DEDUCTIBLES.** These are specified dollar amounts you must pay before Medicare coverage begins. For example, under Part A, you first pay a deductible of \$492 when you go into the hospital, and then your Medicare benefits begin. Another deductible, under Part B, is \$75 for doctor bills and medical supplies.
- **COINSURANCE.** The fixed portion of the bill you must pay is called coinsurance. Under Part A, the coinsurance charge is \$123 per day for the 61st through the 90th days of hospitalization. Under Part B, Medicare pays only 80% of the reasonable charges. The remaining 20% is what you must pay as coinsurance.
- **"REASONABLE" CHARGES.** Medicare will pay a doctor only for "reasonable and customary" charges, which are usually less than the actual charge. For example, if your doctor's bills are higher than what Medicare says are reasonable and customary, you are responsible not only for the 20% coinsurance charge, but for everything over the reasonable and customary charge as well. However, your doctor may be one of many who have agreed to accept what Medicare calls the reasonable and customary charge as payment in full. This is called "assignment." Be sure to check with your doctor to determine if he or she accepts Medicare assignment. If so, you will only have to pay the 20% coinsurance charge for Part B, plus any deductibles which are not met.
- **SERVICES NOT COVERED BY MEDICARE.** Some of the services not covered by Medicare are hospital stays of more than 150 days, skilled nursing home stays of more than 100 days, private duty nursing, drugs outside of the hospital, stays in an intermediate care nursing home or rest home, dental care, and the cost of eyeglasses. Keep in mind this is only a partial listing. For more information about what Medicare pays and does not pay, consult "Your Medicare Handbook" issued by the Health Care Financing Administration. Your local Social Security Office should have copies of this booklet on hand.

How Much Additional Insurance is Needed?

As a rule, your first priority in supplementing Medicare should be to fill in the most costly gaps, particularly deductibles in Part A and the 20% coinsurance in Part B. Also, while the likelihood of a long hospital stay or skilled nursing home stay of more than 100 days is remote, it can be financially devastating if it occurs. You should consider purchasing the relatively inexpensive coverage against this possibility.

Insurance coverage for private duty nursing and other services not covered by Medicare should also be considered. Coverage for custodial or rest home care is generally not available.

Policies covering specific diseases are usually of an indemnity type, and insure against such diseases as cancer, kidney disease and muscular dystrophy. Keep in mind that these policies offer very limited coverage and may not be the wisest investment of your insurance dollar. Such policies should never be considered as a substitute for the more basic types of Medicare supplement policies discussed elsewhere in this booklet.

Where Can I Buy Medicare Supplement Insurance?

Medicare supplement policies are available from several sources. If you worked for the government or if you belong to a large union, you may already have Medicare supplemental coverage through your pension fund. Your fund may also give you the option of joining a Health Maintenance Organization (HMO) which covers the deductibles and coinsurance gaps at little or no additional cost to you. Check with your pension fund office for details.

Three organizations for senior citizens offer a variety of Medicare supplement policies to their members. The policies are usually serviced through the mail and are available to members only. Membership dues for the organizations vary, but are generally under \$10 per year. These organizations can be reached as follows:

American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049
Telephone: 202/872-4700

National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C. 20005
Telephone: 202/347-8800

Ohio Coalition of Senior Citizens Organizations
4156 East 147th Street
Cleveland, Ohio 44128
Telephone: 216/561-7177

Blue Cross and Blue Shield offer a variety of Medicare supplement policies to senior citizens throughout Ohio. Policies are generally serviced through regional offices. The number for the Blue Cross and Blue Shield plans nearest you can be found in the Yellow Pages under "insurance" or through your telephone operator.

Private health insurance companies usually offer Medicare supplement policies and they often sell through agents. If you already have an insurance agent who services your insurance needs, you may want to ask him or her about Medicare supplement policies. If the agent cannot offer one, ask for a recommendation to another company. Friends and relatives can also be helpful by suggesting agents or companies they know. If you have exhausted those resources, the Yellow Pages contains a listing of agents and companies in your area.

Medicare supplement policies are also available through direct mail solicitations, which often appear in Sunday newspaper supplements. These policies are normally serviced from one central location.

Points to Remember When Shopping For Medicare Supplement Insurance

1. Don't buy more policies than you need. Duplicate coverage can be costly and unnecessary. One comprehensive policy is better than several small policies with overlapping coverage.
2. Check to see if a policy will cover pre-existing health conditions. This can be important if you are currently being treated for a specific condition.
3. Check the policy for maximum benefits payable, either in terms of a dollar limitation or a limitation based on the number of days for which payment will be made.
4. Check to see if the policy can be easily renewed. Policies that do not offer guaranteed or automatic renewal are often less desirable.
5. Know your insurance agent. Every licensed agent in Ohio is required to carry proof of licensing which shows his or her name and the names of the companies represented. If you wish to verify an agent's license, contact the Ohio Department of Insurance, 2100 Stella Court, Columbus, Ohio, 43215, telephone: 614/466-3855. Also, write down your agent's name, company, address and telephone number for your own records and keep the information in a safe place.
6. Even though an insurance agent or company is licensed in Ohio, that **does not** mean that the State of Ohio endorses the company, the agent, or the policies offered. It **does** mean the company meets the requirements of Ohio law, including financial soundness.

7. Medicare supplement policies are not sold by or affiliated with the government. You should not do business with any company or agent who claims to be associated with a government-sponsored program.
8. Low-income people who are eligible for the Medicaid program may not need additional health insurance. Medicaid may already pay almost all health costs. If you have questions concerning eligibility or coverage, contact the Ohio Department of Human Services, 30 East Broad Street, Columbus, Ohio, 43215, telephone: 614/466-6420.
9. When changing from one policy to another, do not cancel your existing Medicare supplement policy until you are absolutely certain the new policy is in force. You may actually have to pay two premiums for several months in order to avoid a lapse in coverage.

How Much Should A Medicare Supplement Policy Cost?

Costs vary greatly, depending upon what is and what is not covered under the particular policy you purchase. As you would expect, the more a policy covers, the more it will cost.

In addition to what is covered, policies differ on how much you have to pay out of your own pocket before your policy begins to pay benefits. Some provide what is called "first dollar coverage," which means you pay little or nothing out of your own pocket for covered services.

Another common type of coverage is called "major medical." Small bills of \$15 or \$25 each are not covered unless they add up to larger amounts such as \$1,000 or more. Once that dollar amount is reached, coverage becomes very extensive. By requiring the individual to pay a set amount before the insurance benefits begin, major medical policies can provide coverage at a lower price than first dollar coverage. In exchange, you probably will pay some of your smaller bills out of your pocket.

Some companies offer policies that combine first dollar and major medical coverage. This is the most complete and usually the most expensive insurance coverage you can buy.

Another type of coverage is known as "indemnity" or "supplement income." This coverage is for a specified dollar amount that is paid in cash directly to you, but it is usually in an amount far less than the cost of the service. For example, many of these policies pay \$50 a day while you are hospitalized, but the daily cost of a hospital stay could be over four times that amount. Consequently, indemnity-type policies should only be used to add to your coverage, and not as a substitute for it.

Individual (non-group) Medicare supplement policies that provide the minimum coverages listed in the checklist on the next page of this booklet are generally available in Ohio at a cost of \$150 to \$350 annually. More comprehensive coverage is available at rates between \$350 and \$1,000 annually.

Please note the prices quoted here are for comparison purposes only and are based on 1985 statistics. The price you pay will depend on where you live, how old you are, the insurance company you are dealing with, and the types of benefits you choose.

Checklist For Choosing Medicare Supplement Insurance

Courtesy of Attorney General Anthony J. Celebrezze, Jr.

(Use one checklist for each policy under consideration)

In 1982, the Ohio Department of Insurance issued an administrative order designed to standardize and simplify Medicare supplement policies. No insurance policy described in the rule may be advertised, solicited, or issued in Ohio as a Medicare supplement policy unless it meets the standards outlined in the rule. Even though the rules do not apply to every Medicare supplement policy (for example, it does not cover policies issued to a labor organization for its members) the following list is nevertheless important to consider when selecting any type of Medicare supplement policy. NOTE: Generally speaking, the more "yes" answers you compile in the checklist, the more extensive the coverage. A "no" answer will alert you to coverage you are not receiving. This does not necessarily mean you should not consider purchasing the policy. Some insurance policies do not meet the minimum standards under the law. As such, they cannot be called Medicare supplement policies. They do, however, offer some protection at premiums considerably lower than Medicare supplement policies. If you cannot afford a Medicare supplement policy, you might want to consider one of these lesser policies.

It might be helpful to refer back to the section of this booklet entitled "Where are the Gaps?" when answering some of the questions in this checklist.

Minimum Benefits	Yes	No
Is the waiting period for pre-existing health conditions six months or less?	☐	☐
Are accidents and illnesses treated the same for payment purposes?	☐	☐
Are benefits increased automatically when Medicare deductibles are increased?	☐	☐
If the policy is "noncancellable" or "guaranteed renewable," does it continue in force even if the policyholder's health deteriorates?	☐	☐
If the policy is "noncancellable" or "guaranteed renewable," and if the policyholder's coverage terminates (other than for failure to pay premiums), does coverage for the insured spouse of the policyholder continue?	☐	☐

If a policy is terminated, will it cover losses which began while the policy was still in force (within the limits of the policy)? ☐ ☐

For days 61 through 90, does the policy pay for expenses which would have been paid by Medicare had those expenses occurred during days 1 through 60? ☐ ☐

When your "lifetime reserve" days are exhausted, does the policy pay at least 90% of all Medicare Part A eligible expenses for hospitalization? ☐ ☐

Does the policy pay at least 20% of all Medicare benefits under Part B, including tests, ambulance services, durable medical equipment and outpatient therapy? Is this payment subject to a deductible provision and a maximum payment provision? ☐ ☐

In addition to the standards outlined above, you should check to make sure all policies under consideration contain the following disclosures. Once again, even though the administrative rule discussed above does not require the following disclosures for every Medicare supplement policy issued in Ohio, it nevertheless serves as a guideline for the quality of the policy you are reviewing.

	Yes	No
Does the policy contain a clear statement as to whether or not the policy is renewable and what procedure to follow in order to renew it?	☐	☐
If the policy provides for payment based on "usual and customary" fees (or a similar term), is "usual and customary" defined and explained?	☐	☐
Does the policy have a 10-day or 30-day "free look" provision prominently printed on the policy?	☐	☐
Are policy provisions dealing with pre-existing health condition limitations clearly labeled?	☐	☐
At the time the policy is actually applied for will the insurer deliver to the applicant an outline of coverage which clearly explains the following:		
Types of services covered?	☐	☐
What Medicare pays?	☐	☐
What the policy pays?	☐	☐
What the policyholder pays?	☐	☐

More Comprehensive Coverage

If you want coverage that meets more than the minimum standards, you should determine if the policy contains the following features as well:

	Yes	No
Does the policy pay the Medicare Part A deductible of \$492 for the first 60 days in the hospital?	☐	☐
Does the policy pay the Part A coinsurance charge for days 21 through 100 in a skilled nursing home?	☐	☐
Does it pay for doctor bills that exceed the Medicare "usual and customary" limits?	☐	☐
Does it pay at least 80% of the reasonable expenses for days in a skilled nursing home after Medicare benefits run out?	☐	☐
Does the policy pay at least 80% of home health benefits after Medicare benefits run out?	☐	☐

Additional Coverage

Policies that provide even more coverage are available for a higher cost. The following services are covered in some Medicare supplement policies. You should review each policy to determine exactly what additional coverage it provides and whether you want to pay for such coverage.

	Yes	No
Does the policy pay at least 80% of the costs of any of these services Medicare does not cover at all, such as:		
a. Out-of-hospital prescription drugs?	☐	☐
b. Care in a skilled care facility not Medicare certified?	☐	☐
c. Care in an intermediate care facility?	☐	☐
d. Routine eye care?	☐	☐
e. Dental care?	☐	☐
f. Routine physicals?	☐	☐
g. Cosmetic surgery?	☐	☐
h. Care outside the United States except in limited circumstances?	☐	☐

For More Information

To find out if a specific company or agent is licensed to do business in Ohio, contact the Ohio Department of Insurance, 2100 Stella Court, Columbus, Ohio 43215, telephone: 614/466-3855.

If you would like more information explaining what Medicare does and does not pay, the U.S. Government has prepared a booklet entitled "Your Medicare Handbook." The federal government also puts out a "Guide to Health Insurance for People with Medicare." Both of these publications can be obtained from your local Social Security office.

If you would like a detailed comparison of Medicare supplement policies, the Ohio Department on Aging has prepared "A Buyer's Guide to Medicare Supplemental Health Insurance." It is available for a nominal cost from the department, 50 West Broad Street, 9th Floor, Columbus, Ohio, 43215, telephone: 614/466-1221.

For additional copies of this booklet, write or call:

Attorney General Anthony J. Celebrezze, Jr.
"Closing the Gaps"
30 East Broad Street, 17th floor
Columbus, Ohio 43215
(614) 466-4320

GLOSSARY

AMBULATORY SURGICAL CENTER: A medical facility where surgical procedures are performed on an outpatient basis.

APPLICATION: A signed statement of facts requested by the company on the basis of which the company decides whether or not to sell a policy.

ASSIGNMENT: The signed transfer of benefits of a policy by the owner of the policy to another party, for example, if you tell your insurance company to send a check directly to your doctor or hospital, instead of to you.

BENEFITS: The amount payable in either cash or services to you or a beneficiary under the provisions of the policy when a claim is filed.

CANCELLATION: The termination of an existing policy before it would normally expire.

CLAIM: When you, your doctor, or your hospital notifies your insurance company that you have received a medical service and are requesting payment in accordance with the provisions of your policy.

CO-INSURANCE: A provision frequently found in health insurance policies by which you and the insurance company share a covered loss under a policy in specified ratio. For example, after the deductible has been paid, 80 percent of your expense is paid by the insurance company and you pay the remaining 20 percent.

COMPREHENSIVE HEALTH INSURANCE: A health insurance policy that incorporates the coverages of major medical and basic medical expense policies into one policy.

CONDITIONALLY RENEWABLE POLICY: A policy which may be renewed up to a certain age limit, such as 65, provided all conditions of the insurance contract have been met.

CONVERSION CLAUSE: Privilege granted by a group policy to convert to an individual policy upon termination of group coverage.

COORDINATION OF BENEFITS: If you are covered by more than one group plan, this clause allows insurance companies to determine the percentage of your claim each company will pay. Under this, total benefits will not exceed the actual expenses of your medical care.

COVERED EXPENSE: Medical expenses that a policyholder incurs and the insurance company agrees to pay. The covered expenses that a policy will pay may be found in the schedule of benefits.

CUSTODIAL CARE: Care that is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training.

DEDUCTIBLE: The amount of money you must pay before your insurance benefits begin and you can begin to submit claims. The insurer will pay benefits only on costs above the amount of your deductible.

DISABILITY INSURANCE: A type of insurance that pays you a portion of your previous wages/salary when you are sick or injured and unable to work.

DISEASE-SPECIFIC INSURANCE: Insurance which provides benefits should you develop a specific illness such as cancer or heart disease.

EFFECTIVE DATE: The date on which the insurance under a policy begins.

EXCLUSION: Specific conditions or circumstances listed in the policy for which the policy will not provide benefits.

FIRST DOLLAR COVERAGE: A policy which has no deductibles.

FRANCHISE INSURANCE: A form of insurance in which individual policies are issued to the employees of a common employer or the members of an association. The employer or association collects the premium and sends it to the insurance company. A franchise policy is one way of obtaining "group-like" benefits in an individual policy.

GRACE PERIOD: A period of time (usually 30 or 31 days) after the date a premium is due during which the policy remains in force and the premium may still be paid without penalty.

GROUP INSURANCE: Insurance, usually issued through employers and unions, which covers a group of persons.

GUARANTEED RENEWABLE POLICY: A policy which the insurance company guarantees to renew as long as the premiums are paid on time. During the time insurance is in force the company cannot raise the premium, unless policyholders have their premium raised at the same time.

HEALTH MAINTENANCE ORGANIZATION (HMO): An organization that provides a wide range of comprehensive medical services for a specified group at a fixed monthly payment.

HOME HEALTH CARE: A wide variety of services provided in the home to older, disabled, and/or convalescent persons who do not need institutional care but require some assistance in meeting their home and personal health care needs.

HOSPITAL INSURANCE: Health insurance providing coverage for the costs of hospital care resulting from injury or illness.

INDEMNITY POLICY: A health insurance policy which pays a specified amount of money each day or week that the policyholder is in the hospital. Indemnity policies also pay a set amount for medical and surgical procedures as determined by the insurance company. Generally, an indemnity policy will not cover the entire cost of a hospitalization.

INDIVIDUAL INSURANCE: Policies which provide protection to the policyholder and his/her family. Sometimes called Personal Insurance, as distinct from group or blanket insurance.

INDIVIDUAL PRACTICE ASSOCIATION (IPA): A pre-paid health care plan which is offered by physicians in private practice. An IPA permits an individual to retain their private physician and eliminates paying a fee every time services are received.

INPATIENT: A patient who is admitted to the hospital for medical services and who occupies a bed.

INSIDE LIMIT: A provision in a health insurance policy which limits to a certain amount the payment for any type of service, regardless of the actual cost of the services provided.

INTERMEDIATE CARE FACILITY: An institution licensed to provide health-related care and services to individuals who do not require the degree of care or treatment for which a hospital or skilled nursing facility is designed.

MAJOR MEDICAL INSURANCE: A health insurance policy designed to offset the large expenses of a severe and prolonged illness or injury. Normally, 70 to 80 percent of all medical expenses above a deductible are covered. The insured person as co-insurer pays the remainder up to the stop-loss provision of the plan.

MEDICAID: State programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for medical care.

MEDICAL-SURGICAL INSURANCE: Coverage which provides benefits towards the fees of physicians and surgeons for care provided in the hospital, office, or home. It also covers x-rays and other laboratory tests performed outside the hospital.

MEDICARE: The hospital insurance system and the supplementary medical insurance for the aged created by the 1965 amendments to the Social Security Act.

MEDICARE ASSIGNMENT: When a physician or medical supplier accepts the payment allowed for services under the Medicare program and does not bill the patient for the difference between the normal fee and the Medicare-allowed payment.

MEDIGAP INSURANCE: Those policies which pay all or part of the expenses for health care not covered by Medicare.

OPTIONALLY RENEWABLE POLICY: A health insurance policy which gives the company the right to terminate the coverage at any anniversary or, in some cases, at any premium due date.

OUTPATIENT: A patient who is not admitted to a hospital, but who has services provided in the hospital.

POLICY: Legal document or contract issued by the company to the policyholder which outlines the conditions and terms of the insurance.

POLICY LIMIT: The maximum benefits an insurance company will pay under a particular policy. It may be listed as a maximum for each illness or condition, or total costs paid from the policy, or for a maximum period of time.

PRE-EXISTING CONDITION: A physical and/or mental condition which you have and/or had before you applied for insurance. Insurance companies do not usually cover pre-existing conditions.

PREFERRED PROVIDER ORGANIZATION (PPO): An arrangement where doctors and hospitals form an organization to offer medical services to selected groups at discounted rates. In return for the discounted rate, the doctors and hospitals are guaranteed a certain volume of patients. Members of the groups agree to use only the "preferred" providers for all their medical needs.

PREMIUM: The payment required to keep a policy in force. This payment may be made monthly, quarterly, semi-annually or annually.

REIMBURSEMENT, BENEFITS: The actual expense incurred by the insured, such as medical, nursing, and hospital treatment.

RIDER: A document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage or in any other way amend the original contract.

SCHEDULE OF BENEFITS: A list of specific maximum amounts payable for certain conditions.

SERVICE CONTRACT: When claims are made under a service plan, the insurance company pays the hospital and doctor the full cost of the care they provided. For example, a Hospital and Medical-Surgical policy which pays service benefits that cover the cost for a semi-private room, ancillary services, physical fees, etc.

SKILLED NURSING FACILITY: A facility that is primarily engaged in providing skilled nursing care and related services for patients who require medical or nursing care.

STOP-LOSS LIMIT: The maximum amount that you have to pay within a given period of time (usually per year). Once this maximum is reached, the insurance company will pay 100% of eligible (covered) health care costs.

SURGICAL SCHEDULE: A list of cash allowances attached to the policy, which are payable for various types of surgery, with a maximum amount based upon the severity of the operation.

THIRD-PARTY-PAYOR: Any public or private organization, such as an insurance company, which reimburses medical care providers for services provided to policyholders. An insurance company is the third party between the patient and health care provider.

USUAL, CUSTOMARY, AND REASONABLE (UCR): A charge for medical care which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

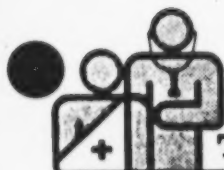
WAITING PERIOD: The length of time an applicant must wait, from the date of an application for coverage to be effective.

WAIVER: The surrender of a right or privilege which is known to exist.

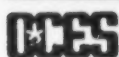
WORKERS' COMPENSATION: An insurance program, usually established by the state, that provides income benefits to employees who are injured while on the job.

Adapted from:

Rooney, Michael. Health Insurance: How To Evaluate And Select Health Insurance. The People's Medical Society, 1985



Making Sense of Health Care Plans: THE CONSUMER'S GUIDE TO HEALTH CARE COVERAGE

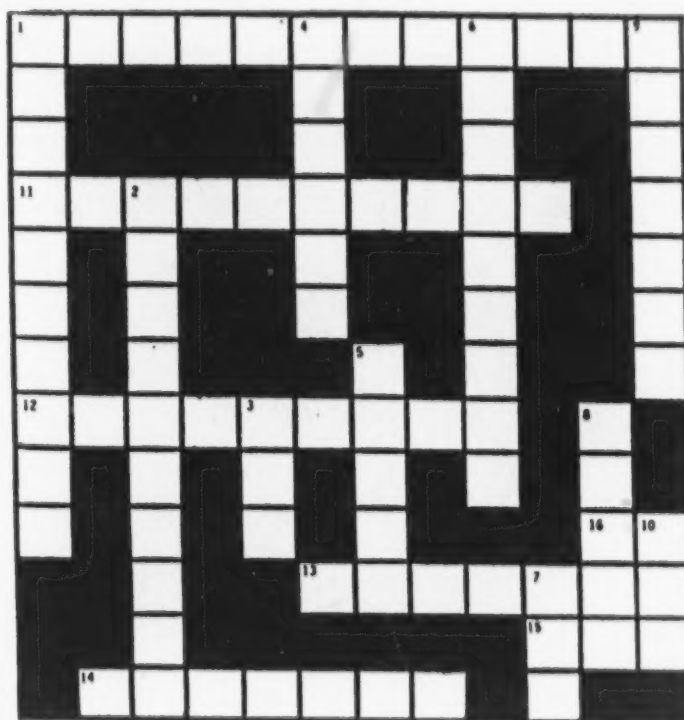


OHIO COOPERATIVE EXTENSION SERVICE
The Ohio State University

CUYAHOGA COUNTY: 3200 West 65 Street • Cleveland, OH 44102-5588 • Phone (216) 631-1890



HEALTH CARE COVERAGE CROSSWORD PUZZLE



ACROSS

1. Signed statements of facts requested by the company on the basis of which the company decides whether or not to sell you a policy.
11. Insurance policies which provide protection to the policyholder and his/her family. It is sometimes called Personal Insurance, as distinct from group or blanket insurance.

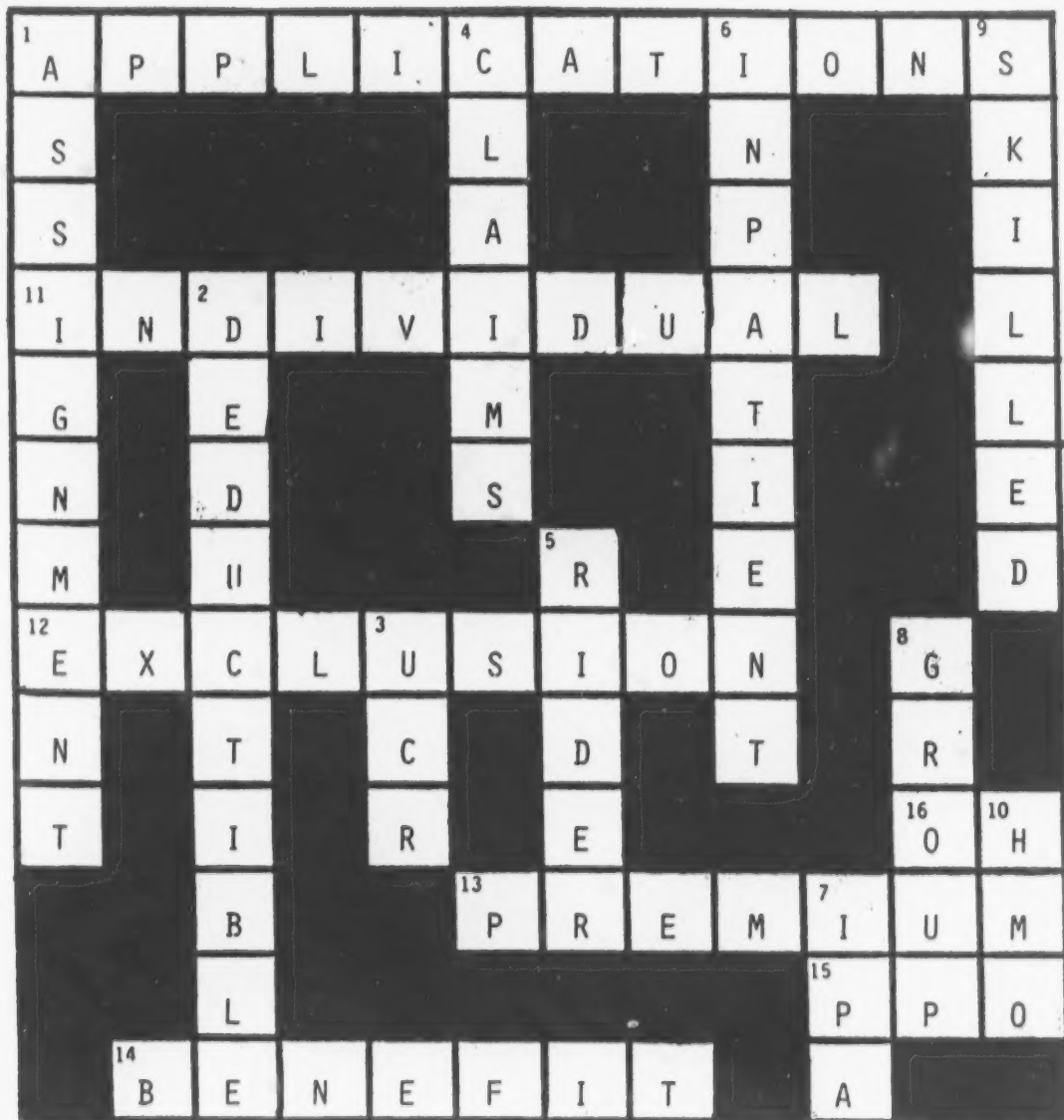
12. Specific conditions or circumstances listed in the policy for which the policy will not provide benefits.
13. The payment required to keep a policy in force. This payment may be made monthly, quarterly, semi-annually or annually.
14. The amount payable in either cash or services to you or some beneficiary under the provisions of the policy when a claim is filed.
15. An arrangement where doctors and hospitals form an organization to offer medical services to selected groups at discounted rates. In return for the discounted rate, the doctors and hospitals are guaranteed a certain volume of patients. Members of the groups agree to use only the "preferred" providers for all their medical needs.
16. Name of state in which you want to be sure the insurance company is licensed to do business.

DOWN

1. The signed transfer of benefits of a policy by the owner of the policy to another party, for example, if you tell your insurance company to send a check directly to your doctor or hospital, instead of to you.
2. The amount of money you must pay before your insurance benefits begin and you can begin to submit claims.
3. A charge for medical care which is consistent with the going rate or charge in a certain geographical area for identical or similar services.
4. When you, your doctor or your hospital notifies your insurance company that you have received medical services and are requesting payment in accordance with the provisions of your policy.
5. A document which amends the policy or certificate. It may increase or decrease benefits, waive the condition of coverage or in any other way amend the original contract.
6. A patient who is admitted to the hospital for medical services and who occupies a bed.
7. A prepaid health care plan which is offered by physicians in private practice and eliminates paying a fee every time services are received.
8. Insurance, usually issued through employers and unions which covers a _____ of persons.
9. Facility that is primarily engaged in providing _____ nursing care and related services for patients who require medical or nursing care.
10. An organization that provides a wide range of comprehensive medical services for a specified group at a fixed monthly payment.

HEALTH CARE COVERAGE CROSSWORD PUZZLE

Answer Sheet



professional standards. Is there a quality assurance program? Is there a patient grievance procedure?

- **COSTS** — Compare the total amount of out-of-pocket costs you might pay under each plan. This involves more than just the premium since many insurance plans require deductibles and co-insurance payments.

- **OUT-OF-TOWN COVERAGE** — What is the coverage if you get sick or hurt out-of-town? What are away-from-home nonemergency benefits?

- **FINANCIAL STABILITY** — How long has the plan been operational?

Try to get recommendations from friends or co-workers who have used the services of the plan. Visit the facility and talk to staff as well.

ALTERNATIVE FORMS OF HEALTH CARE COVERAGE

Prepared by Lindell C. Northup, Program Assistant,
as part of a Research and Training project of the
Cuyahoga County Cooperative Extension Service.

The Ohio State University, 6/86.



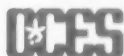
CUYAHOGA COUNTY COOPERATIVE EXTENSION SERVICE

3200 West 65 Street
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ALTERNATIVE FORMS OF HEALTH CARE COVERAGE



MAKING SENSE OF HEALTH CARE PLANS:

THE CONSUMER'S GUIDE TO
HEALTH CARE COVERAGE



CUYAHOGA COUNTY COOPERATIVE EXTENSION SERVICE
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There are two major types of health care plans available which offer an alternative to the coverage provided by traditional health insurance policies. They include health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Health maintenance organizations provide both health insurance and health services through a single organization on a prepaid basis. An HMO either directly provides or arranges for all the health services needed by its members. For a set premium, the HMO agrees to provide comprehensive care from HMO affiliated doctors and hospitals. Sometimes an HMO has its own facilities where doctors are employed as a group to see members. Another type, called Independent Practice Associations (IPAs), contract with doctors in the community who treat HMO members out of their own offices. In addition to providing the health services usually covered by traditional insurance, HMOs provide routine office care and preventive health services with no deductibles or co-insurance. Some charge small co-payments for certain services. Most people join an HMO through an employer but some HMOs also accept individuals, either after a medical screening or during their once-a-year open enrollment period without regard to medical condition.

Some features of HMO plans that are considered desirable by many persons include one premium with few out-of-pocket costs; the elimination of claim forms and improved coordination of services.

However, HMOs also have limitations that are considered undesirable by many consumers, including a more limited choice of doctors, hospitals and other providers and the fact that coverage when traveling may be limited to HMO-defined emergencies.

There is no legal definition of preferred provider organizations, a concept which combines health care financing and services. Unlike HMOs, there are no federal standards for PPOs. Essentially a preferred provider organization is a group of doctors and/or hospitals who contract with a group, such as an employer, insurer, or union, to provide health care to subscribers for a negotiated, usually discounted, fee. PPOs use peer review and strict use controls, such as pre-admission screening, concurrent review of hospitalized patients and retrospective claims reviews to achieve cost savings. PPOs allow subscribers to receive care outside of the plan, even for non-emergency reasons. However, PPO patients have financial incentives, such

as elimination of the deductible and co-insurance requirement, if care is received from PPO providers.

If you are considering joining an HMO or a PPO, you should investigate the plans you are thinking of joining and consider how they compare with your traditional health insurance and each other. Here are some things to consider in your evaluation:

- **BENEFITS** — Compare services available from alternative plans with services covered by your insurance plan.
- **CHOICE OF CAREGIVERS** — What will your choice of doctors be? Can you switch doctors after you have selected one from the list? What specialists could be used? If you have a long-standing relationship with a physician, you should consider carefully if you are willing to switch.
- **LOCATION OF CAREGIVERS** — Are the HMO or PPO affiliated doctors and hospitals as easy for you to get to? Is public transportation available if you need it? What are their hours of operation?
- **QUALITY** — Check to see if the physicians are board certified or eligible. This means they have met rigorous

HOW TO FILE HEALTH INSURANCE CLAIMS AND COMPLAINTS IN OHIO

Prepared by Lindell C. Northup, Program Assistant,
as part of a Research and Training project of the
Cuyahoga County Cooperative Extension Service.

The Ohio State University, 6/86



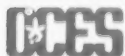
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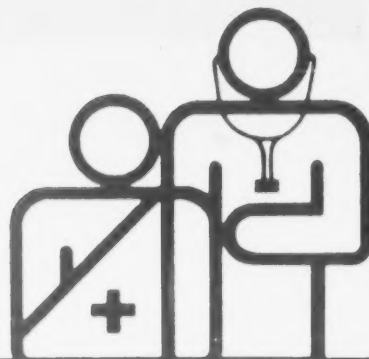
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FILING A HEALTH INSURANCE CLAIM

The most important step before filing an insurance claim, especially with the recent changes in many medical plans, is to understand your coverage. Your claims can only be fully paid if you follow the correct procedures required. Here are some guidelines:

1. Check ahead to see if the medical service or treatment is covered and to what extent it is covered.
2. Ask if your insurance company can be billed directly. You must know the exact process for reimbursement in order to assist the medical staff with your request.
3. Make sure you have a supply of the correct claim forms, if your doctor or hospital does not have the ones required.
4. File claims promptly. Most policies have a time limit on the filing of claims.
5. Discuss your coverage with your doctor or staff. The exact wording of the reason you saw the doctor may make a difference in whether your policy will pay or not.
6. Fill out the necessary form correctly and completely and attach all necessary back-up, such as itemized bills.

7. Keep copies of everything you send to the insurance company, including a record of the date you filed the claim.
8. Follow up promptly if your claim is not paid in the amount of time specified by the company to handle claims. If your claim is denied or only partially paid, you should be given an explanation for the decision.

HOW TO FILE A HEALTH INSURANCE COMPLAINT

If you believe your insurance company has improperly refused to issue or renew your policy, or refused to pay all or part of a valid claim, you have a right to question and complain. Your first step is to contact your agent or company representative.

A complaint by letter is best. Always keep a copy. Include your name, address, telephone, policy number, type of policy and the nature of your complaint. If you decide to complain by telephone, keep a written record of your call, the name of the person you talked to at the company, and what was said during the call.

If you do not receive a response that you agree with, you may contact the Ohio

Department of Insurance who will investigate and determine if the company is within the laws of the state. This consumer protection service is provided by the Department's Policyholders' Service Division which has a toll-free hot line available to all Ohio residents.

When a written complaint is received, one of the Division's investigators is assigned to investigate and answer the consumer's complaints. To reach the department, write:

Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43266

You may call the department's HOT LINE (toll-free) 1-800-282-4658, or use a form provided by the department.

If you are not satisfied with the results of the department's resolution of your complaint, your next option for recourse is to consider taking legal action against the insurance company. Here you will have to weigh the amount in dispute against the additional costs of time and legal fees.

SHOPPING FOR A MEDICARE SUPPLEMENTAL POLICY

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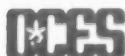
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If you are nearing retirement time and will soon be eligible for Medicare, it is very important that you begin to plan for your continued health care protection. Medicare pays part of certain basic hospital, surgical, and medical costs for people 65 or older. But only 40% of the elderly's health care costs are paid for by Medicare.

The first thing to do is check the group health insurance plan you currently belong to and see if it can be continued after age 65. In many cases the coverage can be continued, but it may be reduced or the premium may increase, or both. Sometimes the policy will be similar to the one you had before but sometimes the new coverage will take the form of a Medicare-Supplemental policy.

Medicare-Supplemental policies, also known as Medigap policies, are designed to fill in some of the gaps in Medicare's coverage. Before evaluating policies, familiarize yourself with these gaps by obtaining a free copy of the government publication called "*Your Medicare Handbook*" from your local Social Security office.

A second publication which you should pick up at the same time is called "*Guide to Health Insurance for People With Medicare*."

There are three kinds of gaps in Medicare's coverage. First, there is the gap represented by deductibles and co-

payments. Then there is the gap between Medicare-approved costs and what providers actually charge. Lastly, there is the gap made up of items Medicare simply does not cover at all. Most Medigap policies concentrate on the first gap — the deductibles and co-payments. Some help out in the other uncovered areas. But many consumers are surprised when their supplemental insurance does not cover the gaps they thought they were protecting themselves from.

Be sure you contact different insurance companies and compare policies because prices can vary considerably. Avoid buying overlapping coverage and policies that insure against only a single disease. One comprehensive policy is usually enough. Be wary of dropping one policy for another; the new one may have waiting periods and pre-existing condition provisions that would leave you for a time with insufficient protection. Look carefully at any pre-existing condition clauses. Policies labeled as Medicare Supplements can't exclude coverage of pre-existing conditions for longer than six months. A policy may, however, exclude all pre-existing conditions. Check your right to renew. Look for a policy with a lifetime guarantee of renewability.

Don't be pressured by a short-term enrollment period. Be sure the insurance agent you are dealing with is licensed to sell in Ohio. Ask to see proof of licensing

showing the name and company. You will also want to be sure that the company you are considering doing business with is licensed to do business in Ohio. Call the Ohio Department of Insurance's HOT LINE (toll-free) at 1-800-282-4658 to be sure. Once you decide on a policy, never pay the premium in cash or make a check out to an individual agent.

Make sure there is a "Free Look" provision giving you at least *ten days* from when you receive the policy to review it. If it is not what you expected or you decide you don't want or need it, or can't afford it, return it promptly to cancel your obligation. Use certified mail and enclose a letter asking for a refund of the premium with the reason for your request. Always keep a *copy* of your letter.

In addition to private companies, group insurance plans are sold through such groups as the American Association of Retired Persons (AARP). Blue Cross and Blue Shield is another source you could investigate. Yet another option is joining a Health Maintenance Organization (HMO) if one nearby you accepts Medicare enrollees.

CONTROLLING YOUR OUT-OF-POCKET INSURANCE EXPENSES FOR HEALTH CARE

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The most obvious way to lower costs for health is to stay as healthy as possible so that you need minimum medical care. Health habits can also play a part in underwriting decisions for individual insurance policies. Some insurers or employers offer reduced premiums or other cash incentives for healthier habits such as non-smoking.

The price of an insurance premium is determined by factors such as the age and sex of the applicant, the extent of coverage and the presence and size of a deductible clause and co-insurance. Individually purchased policies can be 15-40% more expensive than group plans, so try to find group coverage. Prices and coverage vary greatly, so shopping around is important.

In general, if you pay the insurance premium annually or semi-annually, rather than monthly, you may lower the total yearly premium. Ask to see a payment schedule to be sure you are getting a lower rate. This makes financial "sense," however, only if you are satisfied with the coverage, claims servicing, etc. Therefore, you may want to consider paying monthly or quarterly premiums while on a new plan until you are familiar and satisfied with the coverage and services rendered.

The deductible is the dollar amount of medical expenses you must pay each

year before the insurance policy starts paying. If you can budget enough to cover a higher deductible, your premiums should be lower. Also, look for a policy which allows expenses incurred at the end of the year to be carried forward as part of the deductible for the following year.

Co-insurance is the percentage of covered expenses you must pay once the deductible amount has been met. Look for a policy with no more than a 20% co-insurance clause which you would be responsible to pay.

Experts generally suggest you look for a policy which pays "service" benefits rather than cash payments. In that way you can authorize the insurance company to pay for expenses directly, usually at the customary rate.

Look for a policy with a maximum out-of-pocket dollar amount, called stop-loss protection, that you must pay in a year. After that the policy picks up 100% of covered charges. This will help you to budget for the possibility of large expenses.

Review your policy to be sure you are following correct procedures for non-emergency services. Such requirements as second opinions for surgery and permission prior to hospitalization are becoming more common. Penalties for

not following the new "rules" include reductions in the amount paid or complete denial of claims.

Know what your policy covers and be sure that the documentation for a claim from your provider for a covered service is worded correctly. Otherwise, your claim may be denied.

Avoid buying insurance policies that duplicate coverage for the same services. Most companies will "coordinate" their benefits which means you won't be able to collect the same benefits from two or more policies. However, not all policies are alike so you need to be careful since policies can cover different items.

By selecting less expensive providers or procedures, such as outpatient surgery, you can save money. In fact, your coverage may require out-of-hospital care for certain procedures for full payment or may provide a monetary incentive such as waiving the deductible, if you utilize a less expensive option.

Check your medical bills for possible errors. If you have been hospitalized, check your bill to be sure that the length of stay and type of room are correct; that services have not been listed twice; that the price of a service is correct, noting any that seem too high; and that the services

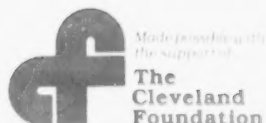
listed on the bill were actually performed. If you find an error, contact both your insurance company and the hospital.

Shop around for a pharmacy that provides the services and prices best for you. When you need a prescription drug, ask your doctor or pharmacist if a generic drug may be dispensed. Often they can be substituted for brand name drugs at considerable cost savings.

SHOULD YOU BUY CANCER INSURANCE?

Prepared by Lindell C. Northrup, Program Assistant
as part of a Research and Training project of the
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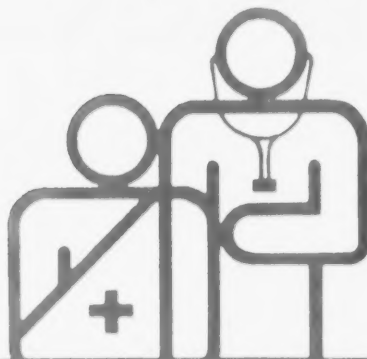
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Cancer insurance is one type of "specific or dread disease" insurance available today. It provides benefits only if you get cancer. Policies vary widely in cost and coverage. Before you buy such a policy, ask yourself these questions:

First, is my current coverage adequate for the costs related to cancer? Find out what your coverage would be under your present health care policy if you should get cancer. Duplicate coverage is often expensive and unnecessary. Since cancer treatment accounts for only a small percentage of United States health expenses, you must first be sure that you have basic health coverage which will cover all conditions, not just cancer. If you are not protected against catastrophic medical costs, you should consider buying a major medical policy which will cover you from any accident or sickness, including cancer. If you are on Medicare and want more insurance, a comprehensive Medicare Supplemental policy is what you need. Or you could consider joining a health maintenance organization.

Second, since insurance is designed to provide a measure of protection from risk, ask yourself how likely you are to contract the disease. While one of four Americans will get cancer over their lifetime, one-quarter of all cancers are skin cancer, the least expensive and most easily cured form. Regardless of this fact, the odds are 3 out of 4 that you will never receive any benefits from such a policy. Studies have shown that most cancer policies pay back less than 50 cents in benefits for each dollar paid in premiums.

Third, ask what the benefits would be, what the policy will not cover, and what the limitations are. Some policies pay only for hospital care. The average stay in a hospital for a cancer patient is only about 15 days. Today more and more types of treatment such as chemotherapy are being done on an out-patient basis. Many cancer policies do not cover expensive follow-up treatments such as drugs, home nursing, physical therapy, special equipment, or nursing home care. In fact, cancer policies cover only an average of

30-40% of the costs associated with the treatment of cancer. Nor will they cover cancer-related illness that may develop from the disease or its treatment. No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it. Other policies contain time limits.

Most experts think cancer insurance is not a good buy. They believe that money used on this type of insurance would be better spent on protection from catastrophic illness of all kinds, or against the loss of income from a disabling illness. Some even suggest additional life insurance as another option. If you do decide to consider cancer insurance, shop around for the best coverages and cost.

After your baby is born, most plans require that you notify the insurer in writing within thirty-one days of birth for assured continuous coverage. Under group plans, if you don't, the child will have to pass a medical exam to qualify for coverage or must wait for an open enrollment period which may be months away.

Remember that the Pregnancy Discrimination Act of 1978 covers only those employers with 15 or more full-time employees who offer health insurance as a benefit. It also has no bearing on individual insurance policies, under which you have to expressly purchase maternity coverage.

HEALTH INSURANCE COVERAGE FOR PREGNANCY AND CHILDBIRTH

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The Pregnancy Discrimination Act of 1978 requires employers of fifteen or more full-time employees who offer a health insurance plan for all employees, to treat pregnancy-related disabilities on an equal basis with all other medical conditions. This means an employer who meets those criteria must provide the same insurance coverage for pregnancy as it provides for illnesses and accidents. Some companies, however, have contended that the law does not apply to wives or unmarried dependent daughters of employees. If a woman is not covered under her own policy, it's important to carefully examine coverage limitations for pregnancy under her husband's policy.

Some individually purchased policies have exclusions for pre-existing conditions, such as pregnancy, for a stipulated period of time (for example, eleven months) which will exclude you from coverage if you were pregnant at the time of enrollment in the insurance plan. Some policies even stipulate that they will not cover a pregnancy if conceived within a certain number of months following enrollment.

In some individual or small group (14 or less employees) policies, if you do not select the maternity option when you signed up, you may not be allowed to add it at a later date. Be sure to think about this if you feel you may need such coverage at some future point.

As with all policies or plans, find out ahead what will be covered, for how long, and how much will be paid. While most group policies provide full maternity benefits, others pay lump sums only for certain procedures, and often the actual charges are much higher.

Find out from your insurer whether your policy covers payments for births attended by a certified nurse-midwife or in an alternative birth setting if you plan to utilize these services. Some plans are providing financial incentives for new mothers who take early hospital discharge, usually in the form of a cash bonus and home nursing care.

If you or your spouse is pregnant and are thinking of changing jobs, be sure you check out the medical coverage you will be acquiring under the new company's plan to be sure that your coverage will be continuous. In some cases you may need to consider converting to an individual policy to be assured of this protection. However, in the case of employers who are "self-funded" for the cost of their employees' health care services, there may not be an insurance policy to which you can convert.

In order for an unmarried dependent to be covered for costs related to pregnancy and childbirth, the family must have both dependent child and maternity coverage.

Coverage would not include, however, the expenses related to well baby care (for example, the pediatrician and nursery charges).

An important point to check out is your policy's provision regarding your newborn child. In the past, many policies contained clauses that excluded coverage for as much as the first 30 days of life — exactly the period that some infants require the most extensive care. New laws have been passed that require new health insurance policies to cover infants from the moment of birth, but old policies, even if they are guaranteed renewable, are not required to conform to these new statutes.

Check your policy to find out if your baby will be covered from birth. If not, after birth, you can consider buying relatively inexpensive limited coverage for the short period of time until the newborn qualifies for regular dependent coverage. On an individual basis, however, the child would have to medically qualify for the coverage. Another option you might consider is enrolling in a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO) before the pregnancy is anticipated. Your other option is to "self-insure" by saving a certain amount of money during the pregnancy to cover many medical expenses incurred until the newborn is covered under the family's plan.

PURCHASING HEALTH INSURANCE

Once you decide on a policy, never pay the premium in cash or make a check out to the individual agent. Complete the application completely and honestly. Do not withhold medical information. Since claims forms often request the same information, it is critical that the original application include essential facts of your health history or future claims may not be paid. Do not sign an application without reviewing what has been written. Carefully review the copy of the application attached to the policy to be certain that it is correct and has not been altered in any way. If you find a mistake, notify the company *in writing*.

Remember, if you have any questions about a policy or plan, it is important that they are answered by a knowledgeable person before you sign up.

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Everyone's health care needs are somewhat unique. But there are some guidelines that apply to each one of us when shopping for health insurance. Keep in mind that buying health care coverage is a major consumer purchase. It's important to be a comparison shopper, and today there are more options than ever. When comparing insurance policies, keep the following important points in mind.

First, be sure that the company you are considering is reliable. Check with the Ohio Department of Insurance by calling toll-free 1-800-282-4658 to be sure the company is licensed to do business in Ohio. Check the company's financial rating in *Best's Insurance Reports* at your public library. Look for companies that return a high portion of the monies paid in premiums in the form of benefits.

Make sure you understand the policy's provisions about what is covered and to what extent and, perhaps more importantly, what is not covered. Know who in your family would be covered and at what age benefits begin and end. Find out how much money you would have to pay before benefits begin. This is known as a deductible and can apply to every family member's medical costs. Look for a policy that includes a maximum deductible for the family as a whole.

The co-insurance provision specifies how you and the insurance company will share the payment of covered services. Look for policies with a co-insurance clause of 20% or less. A stop-loss provision is the maximum out-of-pocket expenses you would be forced to pay after which the insurance pays 100% of covered services. Look for a policy with a stop-loss amount you can reasonably afford.

The maximum level of lifetime benefits is the amount the company will reimburse you for covered medical costs. With today's health care costs so high, look for a policy with at least a \$250,000 maximum.

Exclusions are provisions which limit coverage. This is a very important area for you to check out because it is generally the one upon which claims are denied. Exclusions include waiting periods during which time your policy will not cover a given problem. A waiting period of 11 or 12 months is not uncommon with maternity benefits.

Pre-existing conditions refer to any illness you may have had before the policy was issued. Some policies will not pay for expenses related to pre-existing conditions at all; some specify a waiting period. Shop for a policy with the shortest

period of time during which it will exclude paying benefits for such conditions.

Be sure to check out the prospective policy for riders, which are separate attachments that take away benefits described in the policy itself. If you did not agree to these attachments, consider exercising your right to return the policy, usually within 10 days, with no obligation on your part. Remember, however, to put this in writing so that you have a record of cancellation and a request for a refund if you paid in advance.

Look for a policy that is noncancellable and guaranteed renewable. In this way the company cannot terminate your coverage if you have large medical bills. Also, you have the right to renew until a specified age.

Find out how the benefits are to be paid. Service benefits which pay all necessary and reasonable charges are recommended by experts over indemnity plans which pay a specified amount. Ask also if there is any limitation on where and by whom you may receive your medical care. Be sure you understand what procedures are covered and in what setting. Be especially concerned with outpatient benefits since so many procedures today are done on this basis.